CancerCare NORTHWEST™

Patient Referral Form

Date: _____

Patient Information

Name _____ Date of Birth _____ Social Security _____

Street Address _____ City, State, Zip _____

Home Phone _____ Cell Phone _____

Primary Insurance Provider _____ ID Number _____ Group Number _____

Secondary Insurance Provider _____ ID Number _____ Group Number _____

Referring Physician Information

Referring Physician Name _____

☐ I would like this patient to be seen at CCNW by Dr. _____

Phone _____ Fax _____

☐ I would like this patient to be seen by the next available oncologist

Office Contact Person _____ Reason for Referral _____

Referring Physician Checklist

Along with this form, please provide us the following materials to ensure as smooth a transition as possible:

- ☐ Patient profile containing demographic and insurance information
- ☐ Copy of insurance cards (front and back) and referral if required
- ☐ All pathology reports and special tests (such as Her2Nu or an ER & PR report) and bone marrow biopsies/aspirations
- ☐ Recent labs, including tumor markers (CEA, PSA, ect.)
- ☐ Consultations and progress notes
- ☐ Operative reports, discharge summaries
- ☐ Chemo flow sheets, radiation summaries
- ☐ Actual films or disks (if films are not available on Stentor) and reports on all CXRs, CTs, MRIs, PETs, bone scans, EKGs, MUGAs, *-oscopies and other related tests

Please fax this referral form and the medical information listed in the above *Referring Physician Checklist* to (509) 252-9337. Thank you for your referral.