Lewis and Faye Manderson
Cancer Center
at DCH Regional Medical Center
DCH

New Patient Referral Form Fax to: (205) 330-3261

Date of Referral: ___________________ **Office Contact Name & Number:** ______________________________

Name of Referring Provider: ___________________________ **Phone:** ________________ **Fax:** ____________

Name of PCP: _______________________________________ **Phone:** ________________ **Fax:** ____________

<u>Please attach the following information to this referral</u>:

____ Face Sheet/Demographic Information
____ Insurance Information & Referral if Needed
____ Chemo/Radiation Reports
____ Most Recent Office Visit Notes/ H&P
____ Recent Lab Work/Reports
____ Pathology/ Surgical/Biopsy Reports
____ Imaging/ Disease Specific Studies

Referring to: ______ Medical Oncology/Hematology ______ Radiation Oncology

______ Both Medical & Radiation _____ Breast Cancer Patients (Both Medical & Radiation)

<u>Medical Oncology Physicians (please select one):</u> _____ No Preference or First Available

_____ Dr. Bostick _____ Dr. Evans ______ Dr. Hinton ______ Dr. Hughes

<u>Radiation Oncology Physicians (please select one)</u>: ___No Preference/First Available___Dr. Crew ___Dr. Tucker

<u>Please Circle the Reason for Referral</u>: Breast Cervical Colon CLL/SLL Gastric

Head & Neck Lung Ovarian Pancreatic Prostate

IDA/Hem (please list most recent levels - Hgb:________ Ferritin_________)

Other Diagnosis – Please Specify: ____

Patient's Name: ____ DOB: ________________________

SSN: ___________________________ Primary #:______________________ Secondary #:____________________

Address: ____ City:______________ State:______ Zip:________

Primary Insurance: ________________________________ Contract #:_______________________ Group #:__________

Policy Holder if different than patient: _____________________________ DOB: _____________ SS#________________

Secondary Insurance: ________________________________ Contract #:______________________ Group #:_________

Policy Holder if different than patient: _____________________________ DOB: _____________ SS#________________

****Please fax completed form to (205) 330-3261, along with information/ records requested above. For insurances requiring referrals, the referring doctor's office/patient will be responsible for obtaining the Insurance Auth.****

<u>OFFICE USE ONLY:</u>

Appointment Date: _________________ Appointment Time: ______________ With Dr. _______________________

☐ Patient Notified: ______________________ ☐ We were unable to Reach Patient – Please Notify

Referring Doctor's office called and _________________________________ notified of the scheduled appointment.

Thank you for your referral. We look forward to working with your office and the patient.