**Referral Form**

Date:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Referring Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address of Referring Physician :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone of Referring Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fax of Referring Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email of Referring Physician:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name:

Date of Birth \_\_\_\_\_\_\_\_\_

Physician at Houston Cancer Institute:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for Referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis Code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Information:

Insurance ID:

Effective date of coverage:

Comments/ Special Requests

á       Routine Appointment needed

á       Urgent Appointment needed

á       Special Request

We recommend that the following relevant medical records be sent with the referral

     \*   Pathology Reports (if applicable)

     \*   Diagnosis for which patient is being referred

á      Procedure or operative report (if applicable)

á      All laboratory or diagnostics studies as applicable

á      Doctor office notes

á      Medication Records

á      Insurance information and patient demographic information

The Physicians and Staff at the Houston Cancer Institute, PA thank you for referring your patient to us. and taking the time to complete this form.