CANCER CENTER

Today's Date________________________________

**PLEASE SEND REFERRAL FORM AND RECORDS TO :**

FAX: 901-226-0349

For any question, call 901-226-0340

# NEW PATIENT REFERRAL FORM

Diagnosis/Reason for Referral ____________________________________________

Physician that you are referring to ______________________ ◯ No Preference

How soon would you like the patient to be seen: ______________

Does the person know why they are coming to Baptist Cancer Center? ◯ Yes ◯ No ◯ Unsure

Records required for referral:

◯ Pathology (if applicable) ◯ Most recent progress note ◯ Most recent labs ◯ Imaging

## PATIENT INFORMATION

Name____________________________________________________________

Address_____________________________ City/State ____________________Zip ___________

Home # _____________________________ Secondary Phone # __________________________

DOB ________________________________ SSN#______________________________________

Sex ◯ Male ◯ Female

Does this patient have any communication, language, cultural or ethnic needs? ◯ Yes ◯ No

If so, please describe ____________________________________________________

Patient's preferred language ____________________

Does this patient use any assistive devices (wheelchair, walker etc.)? ◯ Yes ◯ No

If so, please describe ____________________________________________________

## REFERRING PHYSICIAN

Referring Physician ______________________________________________________

Address ________________________________________________________________

Telephone/Fax ___________________________ Contact ____________________________

Is the referring physician the patient's primary care provider? ◯ Yes ◯ No

## PATIENT INSURANCE INFORMATION

Primary Ins. ___________________________ Secondary Ins. ___________________________

Insured_______________________________ Insured ___________________________________

ID# _________________________________ ID# ______________________________________

Policy Holder Name _____________________ Policy Holder's Name _______________________

Date of Birth __________________________ Date of Birth ____________________________

SSN _________________________________ SSN _____________________________________

*Please complete all the blank fields and fax along with the required documents*