NEW PATIENT REFERRAL

ENLOE HEALTH
REGIONAL CANCER CENTER

Reason for Referral______________________________

Diagnosis/ICD-10 Code______________________________

❑ **Emergent** (within 72 hours) Call required.   ❑ **Urgent** (within 7-14 days)   ❑ **Routine**

Please select the department(s) in which the patient needs to be seen:

- ❑ **Comprehensive Breast Care/High Risk**
- ❑ **Hematology/Oncology**
- ❑ **Radiation Oncology**
- ❑ **Genetics**
- ❑ **Lymphedema**
- ❑ **Surgical Oncology**

Preferred Physician (if desired)______________________________

❑ Schedule the patient to be seen by the next available provider in order to be seen in the time frame requested above.

PLEASE COMPLETE THE FOLLOWING INFORMATION:

Date of Referral____________________ Patient Name______________________________

DOB____________________ Patient Phone #______________________________

Referring Provider______________________________

Office Contact______________________________ Office Phone #____________________

Name of patient's Primary Care Provider______________________________

Has patient been informed of referral? ❑ Yes ❑ No

Please include the following to expedite care:

- ❑ Demographics
- ❑ Last Two Office Notes
- ❑ Copy of Insurance Cards
- ❑ Med List
- ❑ Pathology Reports (May be required for URGENT Oncology Consults)
- ❑ Lab Reports (Last 2 years – most recent within 3 months)
- ❑ Radiology Reports (IE. PET CTs, MRIs, CT Scans, Ultrasounds, Mammograms, etc.)
- ❑ Genetic Testing

FAX WITH YOUR OFFICE COVER SHEET AS PAGE ONE

Please FAX completed form and records to New Patient Coordinator

Fax: 530-893-6968 • **Phone:** 530-332-3936

By signing the order, authorization has been provided for the Enloe Health Referral Coordinator to modify the location and/or provider based on clinical and/or insurance purposes.