BAPTIST
CANCER CENTER

Today's Date _____

PLEASE SEND REFERRAL FORM AND RECORDS TO :

FAX: 901-722-0570

For any question, call 901-861-8550

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. _____

Insured _____

ID# _____

Policy Holder Name _____

Date of Birth _____

SSN _____

Secondary Ins. _____

Insured _____

ID# _____

Policy Holder's Name _____

Date of Birth _____

SSN _____

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