Document Type: Orders/Referrals

METHODIST
ESTABROOK CANCER CENTER

HEAD AND NECK SURGICAL ONCOLOGY
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REFERRAL REQUEST FORM

NAME OF PATIENT:_____ **DATE OF BIRTH:**_____

PATIENT PHONE NUMBER/CONTACT INFORMATION:_____

REASON FOR REFERRAL:_____

REFERRING PROVIDER:_____

REFERRING OFFICE PHONE:_____ **FAX:**_____

PREFERRED LANGUAGE:_____

The referral will not be reviewed or scheduled until all of the following documents have been received:

- Completed Referral Form
- Demographic Information and Insurance Cards (actual photo copy of cards)
- Current Medication List
- Recent Office Notes (pertaining to reason for referral, unnecessary documents may result in delay of scheduling)
- Labs (within the last 6 months)
- Diagnostic Testing (i.e.: US, CT, or MRI pertaining to reason for referral) Powershare/PACS images to Nebraska Methodist Hospital.
  - ☐ Cerner patient

Additional scheduling comments:

Office Use Only:

☐ Patient Scheduled
Date/Time:_____
MD:_____

☐ Patient Refused
☐ Referring office contacted

Attempted to contact:
X1:_____
X2:_____
X3:_____

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Patient Label

NAME:_____DOB:_____

FIN:_____MRN:_____

PERMANENT PART OF MEDICAL RECORD