Document Type: Orders/Referral
Subject: Radiation Oncology Referral Form

*DR0126*

METHODIST

# Radiation Oncology Referral Form

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**Date:**_____ **Diagnosis:**_____

**Patient Name:**_____ **DOB:**_____ **Sex:**_____

**Patient Phone Number:**_____**Cell Phone Number:**_____

**Referring Provider:**_____ **Primary Care Provider:**_____

**Referring Office Contact:** _____**Phone:**_____**Fax:**_____

The referral will be scheduled once **ALL** of the following documents have been received:

- ☐ Cerner patient
- ☐ Current Medication List
- ☐ Patients Demographic Page and Insurance Information/Cards
- ☐ Initial consult/two most recent office notes pertaining to reason for consult
- ☐ Diagnostic testing (e.g. CT, MRI, PET, Mammo, X-Ray) Images pushed to Methodist
- ☐ Pathology Reports pertaining to referral diagnosis
- ☐ Recent lab results (prostate patients need PSA/Testosterone)
- ☐ Previous Chemotherapy Yes____ Where_____ Date_____
- ☐ Chemo flowsheet (if applicable) Medical Oncologist_____
- ☐ Previous Radiation Yes____ Where_____ Date_____
- ☐ Prostatectomy Yes____ Where_____ Date_____
- ☐ Biopsy Yes____ Where_____ Surgeon_____ Date_____
- ☐ Surgery Yes____ Where_____ Surgeon_____ Date_____

  Targeted Radiation Start Date_____

Please include any additional scheduling comments (include any **future scheduled tests** or **pending results):**

_____

_____

- ☐ Please check box if patient is aware of referral
- ☐ Interpreter Needed – Language:_____

********** **Thank you for your referral** **********

Appt Date/Time:_____Rad/Onc Physician:_____

*Our office will contact the patient to schedule. A confirmation fax will be sent with appointment information.

1st Attempt:_____ 2nd Attempt:_____ 3rd Attempt:_____

Referring Office Notified: ☐ Faxed Date:_____

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Patient Label

NAME:_____DOB:_____

FIN:_____MRN:_____

**PERMANENT PART OF MEDICAL RECORD**