FLORIDA CANCER AFFILIATES
NORTH FLORIDA

☐ Kazumi Chino, M.D. / Andrew Weber, M.D.
2100 State Ave · Panama City, FL 32405
Phone (850) 763-0036 · Fax (850) 763-0259

☐ Syed. K. Mahmood, M.D. / S. Tariq Mahmood, M.D.
2614 Jenks Ave · Panama City, FL 32405
Phone (850) 769-2996 · Fax (850) 769-4665

Request for Consultation

REFERRING PHYSICIAN INFORMATION

Date: ______________________

Referring Physician's Name: ______________________

Address: ______________________ Fax Number: ______________________

Contact Name: ______________________ Phone Number: ______________________

MEDICAL INFORMATION NEEDED

Gender: ☐ M ☐ F

☐ Name: First: ______________ Middle: ______________ Last: ______________

☐ DOB: ______________ ☐ SS#: ______________

☐ Address: ______________________

☐ Phone #: ______________ ☐ Cell #: ______________ ☐ Work #: ______________

☐ Primary: ______________________ ☐ Secondary: ______________________

☐ If HMO: Referral #: ______________ Authorization: ______________ Exp.: ________

REQUESTED APPOINTMENT

Reason for Referral, Symptoms and Diagnosis: *(please be specific and state area of involvement)* ______________________

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****Along with this referral, *PLEASE* fax recent office notes, pathology reports including ER/PR and HER-2/neu, labs, all imaging reports including MRI's, CT scans, PET scans and ultrasounds, & copies of patient's insurance cards to 352-351-3964.**

Thank you for allowing us to participate in caring for your patient. We will contact the patient regarding this referral within 48 hours.

FLORIDA CANCER AFFILIATES USE ONLY

Chart #: ______________

New Patient Coordinator: ______________

Appointment Date: ______________

Appointment Time: ______________

Physician: ______________

Physician Initials: ______________

☐ Will see only with records

☐ Will see with records attached

☐ Scan prior to consultation

☐ Scan after consultation

Orders:

☐ CBC ☐ CMP ☐ PT/INR

Other: ______________

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