FLORIDA CANCER AFFILIATES
NORTH FLORIDA
www.FloridaCancer.com

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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 #: _____

Please send insurance cards:

☐ Primary: _____ ☐ Secondary: _____

☐ Member ID: _____ ☐ Member ID: _____

☐ If HMO, Authorization #: _____ ***Please attach authorization***

REQUESTED APPOINTMENT

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

_____

_____

REQUESTED APPOINTMENT

***Please send the following records:**

_____	Office Notes	_____	Pathology	**Prostate:**	_____	PSA	**Breast:** _____ Mammo
_____	Operative Notes	_____	PET/CT	**Ovarian:**	_____	CA-125	_____ Ultrasound
_____	Labs	_____	Radiation Past	**Colon:**	_____	CEA	_____ MRI
_____	Scans	_____	Radiation Current		_____	Colonscopy	_____ ER/PR
				Pancreatic:	_____	CA 19-9	_____ HER 2 NEU by FISH
							_____ HER 2 NEU

Please fax to: (State Ave.) 850-763-0259 or (Jenks Ave.) 850-769-4665