FLORIDA CANCER AFFILIATES

☐ 8570 Granite Court • Fort Myers, FL 33908
Phone (239) 313-2740 • Fax (239) 313-2741

☐ 11181 Health Park Blvd., Suite 3020 • Naples, FL 34110
Phone (239) 653-9118 • Fax (239) 653-9108

www.floridacancer.com

REQUEST FOR CONSULTATION

☐ Michael Poiesz, MD

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)* _____

_____

_____

****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: _____

_____

_____