FLORIDA CANCER AFFILIATES

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☐ 2100 State Avenue • Panama City, FL 32405
Phone (850) 763-0036 • Fax (850) 763-0259
Radiation Center

www.floridacancer.com

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)* _____

****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 office of choice.**

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 #: _____ Physician Initials: _____ Orders:

New Patient Coordinator: _____ ☐ Will see only with records ☐ CBC ☐ CMP ☐ PT/INR

Appointment Date: _____ ☐ Will see with records attached Other: _____

Appointment Time: _____ ☐ Scan prior to consultation _____

Physician: _____ ☐ Scan after consultation _____