FLORIDA CANCER AFFILIATES

☐ 3611 Little Road • Trinity, FL 34655
Phone (727) 372-9159 • Fax (727) 376-8703

☐ 13904 Lakeshore Blvd., Ste. 410 • Hudson, FL 34667
Phone (727) 862-5489 • Fax (727) 862-0397

☐ 14535 Cortez Blvd. • Brooksville, FL 34613
Phone (352)596-3622 • Fax (352) 596-0901

☐ 11373 Cortez Blvd., Ste. 200 • Brooksville, FL 34613
Phone (352) 597-4998 • Fax (352) 596-6051

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 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: _____

_____

_____