The US Oncology Network
www.FloridaCancer.com

| ☐ **Ocala** | ☐ **Timber Ridge** | ☐ **Lady Lake** |
|---|---|---|
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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 (352) 620-0419**