# Cancer Care Consultation
*Referral Form*

Oncology and Infusion Center

Please send the completed form by emailing it to **ONCExtPtRecords@jpshealth.org**, faxing it to **817-702-8352** or calling a coordinator at **817-702-8252**. Make sure to include the original diagnoses documents:

- Clinical notes
- Pathology, radiology and lab reports
- Surgical reports
- Treatment summaries

Incomplete referral forms will be denied. Once the referral is processed, our staff will reach out to your patient to schedule an appointment.

## Patient Information

First Name: _____ Last Name: _____

Date of Birth: _____ Social Security Number: _____

Insurance Payor: _____ Group Number: _____

Patient's Phone Number: _____

## Referring Provider Information

Provider's Name: _____ Street Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Fax Number: _____

Office Email Address: _____ PCP Name (if known): _____

## Referral Information

Date of Referral: _____ Reason for Referral: _____

Has the biopsy been done? ☐ Yes ☐ No Has surgery been done? ☐ Yes ☐ No

Name (of person submitting form): _____

Signature: _____

Date (MM/DD/YY): _____

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