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Patient Referral Form

In order to provide your patient timely and efficient service, we ask that you complete this form. Please fax all requested medical records along with this form to our scheduling department at **(712) 794-5264**. Once all of the records are received we will call the patient to schedule their appointment.

Referral Type- Circle: Radiation Oncology Medical Oncology Hematology Infusion Therapy

Reason for Referral- Diagnosis: _____

Patient Name: _____ DOB: _____ Circle: Male/Female

Patient's Street Address: _____ City: _____ State _____ ZIP Code: _____

Patient's Phone Number: (Home) _____ (Cell) _____ (Work) _____

Referring Provider: _____ Phone Number: _____ Fax: _____

Family Physician: _____ Phone Number: _____ Fax: _____

Records Request: Please provide the following and check what is being sent

- Demographics
- Copy of insurance cards front and back
- Last H&P and or office visit including recent surgical/medical/family history
- Current Medication List
- Records from other oncologist if applicable (ex: Mayo Clinic)
- Lab Results from the last 6-12 months
- Surgical and Procedural Reports (colonoscopy, Bronchoscopy, biopsy procedure reports, etc.)
- History of previous cancer treatment- Chemotherapy or Radiation Therapy: Yes or No
 - If Yes: Prior treatment facility: _____
- All pathology reports
- Any recent radiology scans and reports: Yes or No Facility scans performed at: _____
 - Please request Images to be pushed or mailed to St. Anthony Regional Hospital- Requested: Yes or No**
- Prior Authorization if Applicable: _____

Patient Barriers: Language, transportation, physical (hard of hearing, cannot stand, etc.) _____

Additional Notes: _____

Thank you for the opportunity to care for your patients.