Document Type: Orders/Referrals

DR0020

METHODIST

Radiation Oncology Referral Form

☐ **Methodist Estabrook Cancer Center**
Phone: (402) 354-4104
Fax: (402) 354-8761

☐ **Methodist Fremont Health**
Phone: (402) 727-3580
Fax: (402) 727-3618

☐ **Methodist Jennie Edmundson**
Phone: (712) 396-4429
Fax: (712) 396-7644

Date:_____

Patient Name:_____ **DOB:**_____ **Sex:**_____

Patient Phone Number:_____**Cell Phone Number:**_____

Diagnosis:_____

Referring Provider:_____ **Primary Care Provider:**_____

Referring Office Contact: _____

Referring Office Phone:_____ **Fax:**_____

The referral will be scheduled once **ALL** of the following documents have been received:

- ☐ Completed Referral Form
- ☐ Cerner patient
- ☐ Current Medication List
- ☐ Patients Demographic Page and Insurance Information/Cards
- ☐ Initial consult/two most recent office notes pertaining to reason for consult
- ☐ Diagnostic testing (e.g. CT, MRI, PET, Mammo, X-Ray) Images pushed to Methodist
- ☐ Pathology Reports pertaining to referral diagnosis
- ☐ Recent lab results (prostate patients need PSA/Testosterone)
- ☐ Previous Chemotherapy Yes____ Where_____ Date_____
- ☐ Chemo flowsheet (if applicable) Medical Oncologist_____
- ☐ Previous Radiation Yes____ Where_____ Date_____
- ☐ Prostatectomy Yes____ Where_____ Date_____
- ☐ Surgery/Biopsy Yes____ Where_____ Surgeon_____ Date_____

Please include any additional scheduling comments (include any **future scheduled tests** or **pending results)**:

_____

- ☐ Please check box if patient is aware of referral
- ☐ Interpreter Needed – Language:_____

********** **Thank you for your referral** **********

Appt Date/Time:_____Rad/Onc Physician:_____

*Our office will contact the patient to schedule. A confirmation fax will be sent with appointment information.

1st Attempt:_____ 2nd Attempt:_____ 3rd Attempt:_____

Referring Office Notified: ☐ Faxed Date:_____

Confidentiality Notice: *The documents accompanying this transmission may contain confidential or legally privileged information. If you are not the intended recipient, any disclosure or distribution is strictly prohibited. If you are not the intended recipient, please notify the sender immediately and destroy these documents.*

Patient Label

NAME:_____DOB:_____

FIN:_____MRN:_____

PERMANENT PART OF MEDICAL RECORD