Premier
Cancer Care & Infusion Center

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Referral Form

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Patient Information

Patient Name: SSN:

Date of birth: Gender: Phone number:

Address:

Clinical Information | Patient History

*Referring physicians, please make sure referral is complete by faxing all records regarding the patient's diagnosis, including any past records obtained to help ensure a timely appointment

Oncology

- ☐ Referral Reason and diagnosis
- ☐ Oncology consultation note(s)
- ☐ Imaging reports (CT, MRI, PET, mammogram, etc.)
- ☐ Pathology report(s)
- ☐ Surgical report(s)
- ☐ Lab results (CBC, CMP, tumor markers)
- ☐ Radiation oncology notes (if applicable)
- ☐ Chemotherapy records (if applicable)
- ☐ Genetic testing results (if available)
- ☐ Primary care or referring provider notes
- ☐ AUTH if needed (CPT Codes 99203, 99204, 99205 for Consult)

Hematology:

- ☐ Referral Reason and suspected diagnosis
- ☐ Most recent CBC and CMP
- ☐ Iron Studies, B12, folate, reticulocyte count
- ☐ SPEP/UPEP, Immunoglobulin Levels (if applicable)
- ☐ Bone marrow biopsy results (if done)
- ☐ Imaging reports (e.g., if lymph nodes or spleen evaluated)
- ☐ Relevant Historical Labs (especially if chronic condition)
- ☐ Referring Provider's clinical note
- ☐ AUTH if needed (CPT Codes 99203, 99204, 99205 for Consult)

Prior Chemotherapy: Prior XRT:

Provided by:

PCP:

Diagnosis/Symptoms:

Notes:

Referring Physician: Date:

Phone: Fax: