Lewis and Faye Manderson Cancer Center
at DCH Regional Medical Center

New Patient Referral Form
Fax to: 205-330-3261

Date of Referral: _____ **Office Contact Name & Number:** _____

Name of Referring Provider: _____ **Phone:** _____ **Fax:** _____

Name of PCP: _____ **Phone:** _____ **Fax:** _____

Please attach the following information to this referral: ____ Face Sheet/Demographic Information

____ Insurance Information & Referral if Needed ____ Chemo/Radiation Reports

____ Most Recent Office Visit Notes/ H&P ____ Recent Lab Work/Reports

____ Pathology/ Surgical/Biopsy Reports ____ Imaging/ Disease Specific Studies

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Referring to: _____ Medical Oncology/Hematology _____ Radiation Oncology

_____ Both Medical & Radiation _____ Breast Cancer Patients (Both Medical & Radiation)

Medical Oncology Physicians (please select one): _____ No Preference or First Available _____ Dr. Anguiano

____ Dr. Bostick _____ Dr. Evans _____ Dr. Dubay _____ Dr. Hinton _____ Dr. Hughes

Radiation Oncology Physicians (please select one): ___No Preference/First Available___Dr. Crew ___Dr. Tucker

Please Circle the Reason for Referral: Breast Cervical Colon CLL/SLL Gastric Head & Neck Lung

Ovarian Pancreatic Prostate IDA/Hem (please list most recent levels - Hgb:_____ Ferritin_____)

Other Diagnosis – Please Specify: _____

Patient's Name: _____ DOB: _____

SSN: _____ Primary #:_____ Secondary #:_____

Address: _____ City:_____ State:_____ Zip:_____

Primary Insurance: _____ Contract #:_____ Group #:_____

Policy Holder if different than patient: _____ DOB: _____ SS#_____

Secondary Insurance: _____ Contract #:_____ Group #:_____

Policy Holder if different than patient: _____ DOB: _____ SS#_____

****Please fax completed form to (205) 330-3261, along with information/ records requested above. For insurances requiring referrals, the referring doctor's office/patient will be responsible for obtaining the Insurance Auth.****

OFFICE USE ONLY:

Appointment Date: _____ Appointment Time: _____ With Dr. _____

☐ Patient Notified: _____ ☐ We were unable to Reach Patient – Please Notify

Referring Doctor's office called and _____ notified of the scheduled appointment.

Thank you for your referral. We look forward to working with your office and the patient.

Lewis & Faye Manderson Cancer Center – DCH Regional Medical Center
809 University Blvd. E, Tuscaloosa, AL 35401 – Phone:(205)759-7800 Fax: (205)303-3261