Karmanos CANCER INSTITUTE McLaren GREATER LANSING

NEW PATIENT REFERAL FORM

Phone: (517) 975-9500 Fax: (517) 975-9520

Today's Date: _____

Referring Physician Information

Name: _____

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

Office contact phone #: _____ Fax #: _____

Patient has been notified they are being referred to Karmanos Cancer Institute? Yes _____ No _____

Patient Information

Demographic sheet attached: Yes _____ No_____ **(if no, please complete entire form)**

Name: _____

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

Sex: F _____ M _____ Date of Birth: _____

Preferred patient phone #: _____ Alternate phone #: _____ Best time to call: _____ AM PM

Contact person if not patient: _____ Relationship: _____ Phone #: _____

Name of insurance: _____ Insurance contract: _____ Insurance group: _____

Referral Information

Diagnosis/reason for referral: _____

Direct referral to (if applicable): _____

Specialty you would like patient to see (if applicable):	KCI@MGL Cancer Center	KCI@MGL Lake Lansing Road
	____ Medical Oncologist	____ Medical Oncologist
____Radiation Oncologist	____Gastrointestinal Multi-Disciplinary Clinic	____Gynecologic Oncologist
____Breast Surgery Clinic	____Genitourinary Multi-Disciplinary Clinic	____Thoracic Multi-Disciplinary Clinic

Additional information needed by Karmanos Cancer Institute (Fax reports to 517-975-9520)

____Pathology report (path slides will need to be requested**)
____Most recent scans — CT, PET, MRI, Bone Scan, etc. on CD in DICOM format along with reports**
____All labs
____Chart Notes
____Previous cancer treatment including chemotherapy flow and/or radiation flow sheets
____Surgeon/Medical Oncologist/Radiation Oncologist name and contact information, if applicabl

***If Karmanos receives a signed Authorization to Release Medical Records form from the patient, we can request these items on the patient's behalf. This form is available at Karmanos.org/ReferMGL or we can fax/email it to the patient or provider's office.*

Karmanos Office Use Only

Scheduler Name: _____ ***Appointment date:*** _____ □ ***Informed Referring Physician***