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# LDRT Referral Form – Benign Disease

## Flint McLaren Radiation Oncology

## Low-Dose Radiation Therapy (LDRT) Referral Form – Benign Disease

Karmanos Cancer Institute at McLaren Flint
4100 Beecher Rd., Suite A, Flint, MI 48532
Phone: (810) 342-3800 • Fax: (810) 342-4229

**Referral Information**

**Date of Referral:** _____

**Referral Type:**

☐ Physician Referral ☐ Self-Referral

**Service Requested:**

☐ Radiation (LDRT for Benign Disease)

**Referring Physician / Provider Information**

**Referring Provider Name:** _____

**Credentials:** ☐ **MD** ☐ **DO** ☐ **PA** ☐ **NP** ☐ **Other:** _____

**NPI:** _____

**Practice / Clinic Name:** _____

**Office Phone:** _____

**Office Fax:** _____

**Provider Email (for confirmation):** _____

**Primary Contact for Records (if different):** _____

**Contact Phone:** _____

**Benign Condition Suspected / Confirmed**

☐ Plantar Fasciitis ☐ Achilles Tendinopathy ☐ Osteoarthritis (site: _____)

☐ Epicondylitis ☐ Trochanteric Bursitis ☐ Rotator Cuff Tendinopathy

☐ Dupuytren's ☐ Ledderhose ☐ Keloid (primary / recurrent)

☐ Heterotopic Ossification Prophylaxis

☐ Other: _____

**Duration of Symptoms:** _____

**Conservative Treatments Attempted:**

☐ NSAIDs ☐ PT ☐ Orthotics ☐ Steroid Injection ☐ Shockwave

☐ Other: _____

PT.

MR.#/RM

DR.

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# Patient Information

**First Name:** _____ **MI:** _____ **Last Name:** _____

**Preferred Name:** _____

**DOB (MM/DD/YYYY):** _____

**Sex:** ☐ **Male** ☐ **Female** ☐ **Other:** _____

**Primary Phone:** _____ **Alternate:** _____

**Best Time to Call:** ☐ **AM** ☐ **PM**

**Contact Person (if not patient):** _____

**Relationship:** _____

**Phone:** _____

**Address:** _____

**City:** _____ **State:** _____ **ZIP:** _____

## Clinical Background

**Previous Cancer Diagnosis:** ☐ **Yes** ☐ **No**

**If yes, specify:** _____

**Previous Radiation Treatment:** ☐ **Yes** ☐ **No**

**If yes, site/dose/date:** _____

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## Patient Information (continued)

**Imaging Available:**

☐ **X-ray** ☐ **MRI** ☐ **Ultrasound** ☐ **CT**

**Imaging Date(s):** _____

**Surgeon:** _____ **Phone:** _____

**Specialist:** _____ **Phone:** _____

**Required Documents (Attach)**

- Recent clinic notes
- Procedure reports (if applicable)
- Prior radiation records (if applicable)
- Imaging (DICOM preferred)
- Pathology (if applicable)
- Insurance authorization (if required)

**Please complete this form and fax to (810) 342-4229 or send via secure DICOM upload.**

This form is designed for printing and manual completion.

For a fillable PDF version, contact the Radiation Oncology department.

PT.

MR.#/RM

DR.