BARBARA ANN Karmanos CANCER INSTITUTE
Wayne State University

New Patient Referral Form

Fax completed form to 313-576-9827, call 877-527-6266, or email newpt@karmanos.org to refer your patient to Karmanos Cancer Institute

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): ____ Medical Oncologist ____ Surgical Oncologist ____ Radiation Oncologist
_____ High Risk Breast Clinic _____ Genetic Testing _____ Phase I

Additional Information Needed by Karmanos Cancer Institute

Fax reports to 313-576-9827

_____All labs
_____Chart Notes
_____Molecular Profiling/Tumor Genetics
_____Most recent scans – CT, PET, MRI, Bone Scan, etc. on CD in DICOM format along with reports**
_____Pathology report (path slides will need to be requested**)
_____Previous cancer treatment including chemotherapy flow and/or radiation flow sheets
_____Surgeon/Medical Oncologist/Radiation Oncologist name and contact information, if applicable

***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 on our website, https://www.karmanos.org/Referral-Materials or we can fax/email it to the patient or provider's office.*

Karmanos Office Use Only

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