

Lancaster Cancer Center

1858 Charter Lane Suite 202, Lancaster, PA 17601

Date: ____/____/____

Medical Oncology/Hematology Consult Request

To: New Patient Scheduler

Phone: 717-291-1313 opt. 3

Fax: 717-291-6866

Email:

____@lancastercancercenter.com

From:

Sender's Phone #: _____

Sender's Fax #: _____

Patient Profile Demographics sheet attached Yes No

Patient Name: _____ DOB: ____/____/____ Sex: M F
Last First MI

Patient Address: _____
Street City State Zip

Home Phone: () _____ Mobile Phone: () _____

Referring Physician Information

Referring Physician: _____ Phone: _____ Fax: _____

Physician Signature: _____ Urgent w/in 48 hrs 1- 2 weeks other _____

Reason for Consult: _____ I am requesting: consult only ongoing care

Surgery/Diagnosis Date: _____ Hospital: _____ MRN#: _____

Primary Care Physician: _____ Phone: _____ Fax: _____

Insurance *Please note we may have to reschedule the patient's appointment if we do not receive the referral one day prior to the appointment.

Primary Carrier: _____ Phone#: _____

Insurance Company Address:

Street City State Zip

ID #: _____ Group: _____ Insured: _____ DOB: ____/____/____

Auth/Ref#: _____ Pending Not Required

Secondary Carrier: _____ Phone#: _____

Insurance Company Address:

Street City State Zip

ID #: _____ Group: _____ Insured: _____ DOB: ____/____/____

Auth/Ref#: _____ Pending Not Required

Patient Name: _____ Date: ____/____/____

In order for our physician to provide you and your patient with the best possible consultation, we will need the following medical records PRIOR to the scheduled appointment:

For a CANCER DIAGNOSIS:

- All surgical pathology reports pertaining to diagnosis
- Latest lab work: especially blood counts
- Any previous PET scans, CT scans, MRI, x-ray, mammogram reports
- Any previous chemotherapy/radiation treatment notes
- Physician's progress notes

For a BLOOD DISORDER:

- o Lab work for the last 2 years, especially blood counts
- o Any previous PET scans, CT scans, MRI, x-ray, Mammogram reports
- o Any previous **bone marrow pathology reports**
- o Physician's progress notes

- o If the patient has insurance that requires a referral, we kindly request the referral within 24 hours of scheduled appointment. If we do not receive within the requested time frame we may ask the patient to reschedule.
- o The above records/referrals can be faxed to **717-291-6866**.
- o Failure to provide all the required information will result in unnecessary delays. Thank you for your assistance.
- o If you have not received a confirmation of patient's appointment with 3 business days please call 717-291-1313 opt.3

FOR INTERNAL USE ONLY

Appointment

*Appointment Date: ____/____/____ Time: _____

Physician: _____

New Patient Packet Mailed

Chart Prep Notified