



NEW PATIENT REFERRAL FAX: COLUMBIA

To: Missouri Cancer Associates Fax: 573-443-3627 Phone: 573-874-7800 # of pages: _____

Referral Office: _____ Phone: _____ Fax: _____

Diagnosis/Reason for Consult: _____ Second Opinion

Patient: (last) _____ (first) _____ (M.I.) _____ DOB: _____

Social Security #: _____

Please include the following information with this coversheet:

Medical Oncology Radiation Oncology

Insurance:

- Patient Face Sheet
- Insurance cards – front and back, primary and secondary
- Referral (if applicable)

Physician Preference, if any:

Medical Records:

Oncology Patients	Hematology Patients
<input type="checkbox"/> All pathology reports (include surgical pathology) <input type="checkbox"/> Breast cancer: include ER, PR, her-2-neu <input type="checkbox"/> Last 2 years of labs <input type="checkbox"/> All radiology reports including chest X-rays, mammograms, CT, MRI, PET, bone scans, EKG, venous doppler, Dexa scans and ultrasounds <ul style="list-style-type: none"> • If scans were not performed at Boone Hospital, where: _____ • Bring outside CT, PET, and/or MRI films <input type="checkbox"/> All referring physician notes including: relevant consult notes, op notes, procedure notes and any hospital records <input type="checkbox"/> Most recent medication list	<input type="checkbox"/> All labs (including last 2 years CBC) <input type="checkbox"/> All referring physician notes including: relevant consult notes, op notes, procedure notes, and any hospital records (include marrows). <ul style="list-style-type: none"> • Non-Boone Hospital records, where: _____ • Bring outside CT, PET, and/or MRI images on cd <input type="checkbox"/> Most recent medication list
<input type="checkbox"/> Include any DNR, Advanced Directive or Living Will information (both Oncology and Hematology)	

Comments: _____

MCA Staff Use:

Patient Scheduled: No / Yes Appt. Date: _____ Time: _____ am / pm Physician assigned: _____

All information received: No / Yes Patient Notified: No / Yes Referring Dr. Notified: No / Yes (if yes, by: phone or fax)

Ref Dr. Staff: _____ NP Packet Mailed: No / Yes MCA Staff Initials: _____