Fresno Cancer Center
A USCMC Cancer Treatment Center

**7887 North Cedar Avenue Fresno, CA 93720**
Main: (559) 437-1000
Fax: (559) 437-3870

# New Patient Referral Form

Fax completed form to (559) 437-3870

Today's Date: _____

## Referring Physician Information

Name:_____

Address:_____ City:_____

State:_____ Zip:_____

Office Contact Phone #:_____ Fax #: _____

*Patient has been notified they are being referred to Fresno Cancer Center? 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 #: _____

## Referral Information

Diagnosis (ICD-9)/ reason for referral:

_____

Direct referral to (if applicable): _____

*Additional Information Needed by Fresno Cancer Center (if applicable)

_____Insurance Information
_____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 applicable

Fresno Cancer Center Office Use Only

Scheduler Name:_____ Appointment Date: _____ ☐ Informed Referring Physician