Lancaster Cancer Center

703 Lampeter Road, Lancaster, PA 17602

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:

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

- 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.
- The above records/referrals can be faxed to **717-291-6866.**
- Failure to provide all the required information will result in unnecessary delays. Thank you for your assistance.
- 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