Print Form

COWELL FAMILY CANCER CENTER

MUNSON MEDICAL CENTER

ONCOLOGY REFERRAL FORM

☐ **MEDICAL ONCOLOGY:**
Hughes, Kier, Kohler, Riddle, Koller, Gordon, Hector-Word, Ruch

☐ **GYNECOLOGIC ONCOLOGY:**
David P. Michelin

☐ **RADIATION ONCOLOGY:**
Brown, Heimburger, Prust

PROVIDER CHOICE:
☐ First Available
☐ Preferred provider(s):

☐ **MULTI-DISCIPLINARY THORACIC ONCOLOGY CLINIC**
(Lung/Esophageal/Thymus Cancer Clinic)

☐ **CANCER GENETICS CLINIC**

IS TREATMENT DEPENDENT UPON GENETIC TESTING RESULTS?
☐ YES ☐ NO

PLEASE ATTACH MOST RECENT OFFICE NOTES, MEDICATION LISTS, OUTSIDE RECORDS RELEVANT TO REFERRAL (NOT IN POWER CHART), DEMOGRAPHICS AND COPIES OF CURRENT INSURANCE CARDS AND FAX COMPLETED FORM TO 231-392-8405.

PATIENT'S LEGAL LAST NAME:	PATIENT'S LEGAL FIRST NAME:	DOB:
MRN:	PREFERRED PATIENT PHONE NUMBER(S):	

DIAGNOSIS:

ICD10 CODE(S):

IS PATIENT PRESENTLY SYMPTOMATIC?
☐ YES ☐ NO IF YES, DATE: LIST SYMPTOM(S):

HAS THIS INDIVIDUAL EVER BEEN EVALUATED BY ANY ONCOLOGIST/HEMATOLOGIST/GYNECOLOGIC ONCOLOGIST?
☐ YES ☐ NO IF YES, NAME:
LOCATION: TIME FRAME:

PRIOR RADIATION THERAPY:
☐ YES ☐ NO IF YES, NAME OF FACILITY: BODY SITE TREATED:

REFERRING PROVIDER

NAME:	PHONE#	DIRECT MESSAGING EMAIL:
OFFICE CONTACT NAME:		OFFICE CONTACT PHONE#

PRIMARY CARE PROVIDER

NAME:	PHONE#	DIRECT MESSAGE EMAIL:
OFFICE CONTACT NAME:		OFFICE CONTACT PHONE#

****FOR OFFICE USE ONLY**** *IN ARIA?* ☐ YES ☐ NO IS IT OKAY TO CONTACT PATIENT FOR APPOINTMENT? ☐ YES ☐ NO

	POWERCHART	REQ. DATE:	ATTACHED
H&P/OFFICE NOTES:	☐		☐
PATHOLOGY:	☐		☐
SLIDES:	☐		☐
LABS:	☐		☐
RADIOLOGY:	☐		☐
OPERATIVE NOTE:	☐		☐

		OKAY TO CALL?	LEAVE DETAILED MESSAGE?
PT HOME PHONE:		☐ YES ☐ NO	☐ YES ☐ NO
PT CELL PHONE:		☐ YES ☐ NO	☐ YES ☐ NO
PT WORK PHONE:		☐ YES ☐ NO	☐ YES ☐ NO
PT EMAIL:			☐ YES ☐ NO

Physical Address:
217 Madison St.
Traverse City, MI 49684

Mailing Address:
1105 Sixth St.
Traverse City, MI 49684
231-392-8400 voice

231-392-8405 fax
Patient referrals only

munsonhealthcare.org/cancer
cancerservices@mhc.net