CARTI HEAD AND NECK SURGICAL ONCOLOGY

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PATIENT REFERRAL

PATIENT INFORMATION — Please Print **MRN or SSN** _____

NAME_____ DOB _____/_____/_____

ADDRESS_____ CITY_____ STATE/ZIP_____

EMAIL_____

PHONE _____ ALTERNATE PHONE _____

REASON FOR REFERRAL

DIAGNOSIS _____

_____

PREFERRED CARTI PHYSICIAN _____

❍ FIRST AVAILABLE PHYSICIAN

CLINIC INFORMATION

REFERRING PROVIDER

_____

FACILITY

_____

CONTACT NAME

_____

PHONE_____

FAX_____

PRIMARY CARE PHYSICIAN

_____

TO REFER, PLEASE INCLUDE THE FOLLOWING:

❍ **Demographic Sheet (most recent)**

❍ H & P/Office Note ❍ OP/Procedures

❍ Pathology ❍ Radiology

NOTES: _____

_____

* Patients will be seen within 7 business days.

Note: You will be notified when the patient has been scheduled.