Tesiero Cancer Center - Radiation Oncology Referral Form

Fax: (518) 839-0574 | Phone: (518) 839-0587

Patient Information

Full Name: _____

Date of Birth: _____ / _____ / _____

Phone Number: (_____) _____-_____

Referring Provider Information

Provider Name: _____

Practice Name: _____

Phone Number: (_____) _____-_____

Fax Number: (_____) _____-_____

NPI #: _____

Reason for Referral / Diagnosis

[ ] Consultation Only

[ ] Evaluation for Radiation Therapy

[ ] Second Opinion

[ ] Other: _____

Primary Diagnosis / ICD-10 Code: _____

Pertinent History / Notes:

_____

_____

Supporting Documentation (please attach or fax):

[ ] Pathology Report

[ ] Radiology (CT/MRI/PET)

[ ] Clinical Notes

[ ] Insurance Authorization (if required)

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Fax: (518) 839-0574 | Phone: (518) 839-0587

[ ] Other: _____

Preferred Contact for Scheduling (if not patient):

Name: _____ Phone: _____

Submit via Fax: (518) 839-0574

For Questions: Call (518) 839-0587