

Cancer Center Referral Form

Please administer treatment of this patient at the following location:

BEAUMONT

Altus Cancer Center

Phone: 409.981.5510

Fax: 409.981.5511

310 North 11th St., Beaumont, TX

Port Arthur

Cancer Center of Southeast Texas

Phone: 409.729.8088

Fax: 409.729.8089

8333 9th Ave., Ste G, Port Arthur, TX

Radiation Oncology

Joseph Kong, M.D., FACR, FASTRO • Danny Chow, M.D.
Ernest Hymel, M.D., PhD • Peter Morgan, M.D.
Micah Monaghan, MD

Medical Oncology/Hematology

Harry Smith, M.D.

Patient Navigation

Thank you for your referral and entrusting us with the care of your patient.

Our office will confirm an appointment with the patient. Your office will be notified of the appointment date and time. To expedite the process, **please fax all records that pertain to the reason why the patient is being referred; please see recommended list below.** Thank you for your assistance in this important matter.

Referral Date: _____

Patient name: _____ Date of Birth: _____

Patient's Phone: Home _____ Cell _____

Referring Physician & office contact: _____/_____

Referring physician phone: _____ Fax _____

PCP Name/Phone: _____

Diagnosis & date: _____ Ins. Authorization #: _____

*******Cancer diagnoses must include ALL Pathology History *******

Hematology Patients Only – Must have CBC with Manual Diff

Copy of Insurance/Driver's License
Demographic/Face Sheet
Medication List
Operative reports
Consults/H & P/Office notes
Discharge summaries

Pathology Reports -ALL
Lab history -ALL
Bone Scan/PET/Ultrasounds
Colonoscopy/Endoscopy – ALL
Imaging/CT /MRI/PET – ALL

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