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 <u>ALL</u> 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