Lung Cancer Center

Phone: 352.265.0649

New Patient – Fast Fax Referral
Please fax to 352.627.4179
Attention: Lung Cancer Center Representative

Please include diagnostic studies, most recent H&P and notes, and patient's insurance card.

PATIENT INFORMATION:

Patient Name: ____________________

DOB: __________ SSN: __________ ☐ Male ☐ Female

Address: ____________________

City / State: ____________________ ZIP: __________

Home Phone: __________ Alt. Phone: __________

Insurance Information: ____________________

____

Diagnosis: ____________________

Request Consult with:

☐ Multidisciplinary clinic

☐ Specialist(s): ______ ____________________

____

Reason for referral: ____________________

Referring Physician Information

Name: __________ Contact: __________

Address: ____________________

City/State: __________ ZIP: __________

Phone: __________ Fax: __________

Specialty: ____________________

Primary Care Physician Information (if other than referring MD)

Name: __________ Phone/Fax: __________

Address: ____________________

City/State:__________ ZIP:__________