McLaren HEALTH CARE

Karmanos CANCER INSTITUTE

LOCATIONS:

☐ 4100 Beecher Rd., Flint, MI 48532 • Phone: (810) 342-3801 • FAX: (810) 342-3856

☐ 3140 W. Campus Rd., Bay City, MI 48706 • Phone: (989) 667-2325 • FAX: (989) 671-1353

New Patient Referral — GYN/ONC — Benjamin Mize, MD
GYN/ONC — Naryn Jankowiak NP

This form may be faxed or emailed with attention to the Patient Navigator.

Date: _____ ☐ **Physician Referral** ☐ **Self-Referral**

Patient Information

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

DOB: _____ / _____ / _____ Sex: ☐ Male ☐ Female

SSN: _____ - _____ - _____

Primary Phone: (_____) _____ - _____ Alternate Phone: (_____) _____ - _____

Best time to call: _____ ☐ AM / ☐ PM

Contact Person (if not patient): _____ Relationship: _____

Contact Phone: (_____) _____ - _____

Primary Physician: _____ Office Phone: (_____) _____ - _____

Referral Information

Diagnosis / reason for referral: _____

_____

Previous diagnosis of cancer: _____ Previous radiation treatment: ☐ Yes / ☐ No

Surgeon: _____ Office Phone: (_____) _____ - _____

Specialist: _____ Office Phone: (_____) _____ - _____

McLaren Physician Requested: _____

Patient Insurance Information

**As of 11/18/2019 Meridian Health Plan is out of network and we cannot consult.

Primary: _____

Contract #: _____ Group #: _____

Secondary: _____

Contract #: _____ Group #: _____

Referring Physician Information

Referring Physician: _____

Address: _____ City: _____ State: _____ Zip: _____

Office Phone: (_____) _____ - _____ Office FAX: (_____) _____ - _____

Patient has been notified they are being referred to Karmanos Cancer Institute at McLaren Flint and/or McLaren Proton Therapy Center? ☐ Yes / ☐ No

Additional Information Needed

☐ Pathology report (path slides will need to be requested**)

☐ Most recent scans — CT, PET, MRI, Bone Scan, etc. on CD in DICOM format along with reports**

☐ All labs

☐ Chart Notes

☐ Previous cancer treatment including chemotherapy flow and/or radiation flow sheets

☐ Surgical Oncologist: _____ Office Phone: (_____) _____ - _____

☐ Medical Oncologist: _____ Office Phone: (_____) _____ - _____

☐ Radiation Oncologist: _____ Office Phone: (_____) _____ - _____

Self-Referral:

Are you a previous Karmanos or Gynecology/Oncology patient? ☐ Yes / ☐ No

How did you hear about this clinic?

☐ Physician	☐ McLaren Website	☐ Online Ad
☐ Friend or Family Member	☐ Social Media	☐ Billboard
☐ Mail	☐ Radio	☐ Community Event or Seminar
☐ Internet Search	☐ Newspaper or Magazine	☐ Other: _____

Office Use Only:

Scheduler: _____ Date: _____ / _____ / _____

Physician Assigned: _____

Scheduled Appointment Date & Time: _____ / _____ / _____ _____ : _____ ☐ AM / ☐ PM