



New Patient Referral Form

Fax completed form to 313-576-9827, call 877-527-6266, or email newpt@karmanos.org to refer your patient to Karmanos Cancer Institute

Today's Date: _____

Referring Physician Information

Name: _____

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

Office Contact Phone #: _____ Fax #: _____

Patient has been notified they are being referred to Karmanos Cancer Institute? Yes: _____ No: _____

Patient Information

Demographic sheet attached: Yes _____ No _____ (if no, please complete entire form)

Name: _____

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

Sex: F _____ M _____ Date of Birth: _____

Preferred Patient Phone #: _____ Alternate Phone #: _____ Best time to Call: _____ AM PM

Contact Person if not patient: _____ Relationship: _____ Phone #: _____

Name of Insurance: _____ Insurance Contract: _____ Insurance Group: _____

Referral Information

Diagnosis/reason for referral: _____

Direct referral to (if applicable): _____

Specialty you would like patient to see (if applicable): _____ Medical Oncologist _____ Surgical Oncologist _____ Radiation Oncologist
_____ High Risk Breast Clinic _____ Genetic Testing _____ Phase I

Additional Information Needed by Karmanos Cancer Institute

Fax reports to 313-576-9827

- _____ All labs
- _____ Chart Notes
- _____ Molecular Profiling/Tumor Genetics
- _____ Most recent scans – CT, PET, MRI, Bone Scan, etc. on CD in DICOM format along with reports**
- _____ Pathology report (path slides will need to be requested**)
- _____ Previous cancer treatment including chemotherapy flow and/or radiation flow sheets
- _____ Surgeon/Medical Oncologist/Radiation Oncologist name and contact information, if applicable

**If Karmanos receives a signed Authorization to Release Medical Records form from the patient, we can request these items on the patient's behalf. This form is available on our website, <https://www.karmanos.org/Referral-Materials> or we can fax/email it to the patient or provider's office.

Karmanos Office Use Only

Scheduler Name: _____ Appointment Date: _____ ☐ Informed Referring Physician