Goshen Center for Cancer Care

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RAPID REFERRAL FORM

***To expedite the process, please reference Required Oncology Records Checklist to be included with referral.**

If sending the C-CDA, this form does not need to be filled out. Please be sure to include reason for referral and indicate if records are available in Meditech.

Today's Date:

DEMOGRAPHICS PLEASE VERIFY BELOW INFORMATION IS INCLUDED IF ATTACHING DEMOGRAPHIC SHEET FROM YOUR FACILITY'S EMR

Name: _____ Birthdate:_____ M____F_____

Address:_____ City:_____ State:____Zip:_____

Preferred patient phone #:_____ E-mail:_____

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

Language preferred:_____ Interpreter needed: Y____N_____ Social Security#_____

INSURANCE

Insurance Co._____ Policy#_____ Group #_____

REFERRAL

Reason for referral: _____ Second opinion? Y_____N_____

Diagnosis:_____ Date of diagnosis:_____ Has patient received treatment? Y___N___

Referring Physician:_____ Specialty_____

Address:_____ City:_____ State:____Zip:_____

Phone#_____ Fax#_____ Direct messaging email:_____

Provider choice: First available_____ Preferred Provider(s):_____

COMMUNICATION

You will receive faxed confirmation once the appointment is scheduled. Our office will directly contact your patient with scheduling information. Thank you for referring your patient to Goshen Center for Cancer Care.