Stanford HEALTH CARE
STANFORD MEDICINE

CANCER CENTER REFERRAL REQUEST FORM

Thank you for choosing Stanford Health Care. We look forward to partnering with you in your patient's care.
Please note which location this is for:

☐Palo Alto ☐South Bay ☐Redwood City ☐Emeryville

Date: _____
# of pages faxed _____
☐ Routine ☐ **URGENT**

Phone: (877) 254-3762 | Fax: (650) 320-9443
Email: ReferralCenter@stanfordhealthcare.org

Referring Provider Information:

Referred by (MD): _____ Medical Group: _____

Phone: _____ Fax: _____ NPI: _____

Address: _____ City/Zip: _____

Patient Information:

Last Name: _____ First Name: _____ MI: _____

DOB: ____/_____/_____ Gender: ☐M ☐F Phone: _____ HT: ____ WT: _____

Patient's Address: _____ City: _____

State: _____ Zip: _____ Needs Interpreter? ☐Y ☐ N Language: _____

Insurer: _____ ID #: _____

Reason for Referral:

Diagnosis/ ICD 10: _____ Service/ Specialty Requested: _____
Type of Visit:
☐ **Consultation** ☐ **2nd Opinion** ☐ **Follow-Up** ☐ **Surgery** ☐ **Clinical Trials** ☐ **Tumor Board**
☐ **Cancer Support Services**

Physician Requested: _____
If requested physician unavailable, can patient be seen by another provider? ☐Yes ☐No, contact MD

Documents Required (please fax with this form):

- Tumor Board
- Clinical Trials
- Genetic / Molecular Testing
- Radiation Oncology Results
- Lab Reports
- Chemotherapy Treatment Records
- Pathology (biopsy results)
- Operative Reports for Cancer Surgeries