Texas Medical Center
Cancer Center Referral Form

Please fax this form, along with patient medical records, including labs, imaging reports, procedure reports, medication lists (including chemotherapy) and patient demographics to 713.704.5922. For any questions, please do not hesitate to contact our office at 713.704.2833.

Reason for Cancer Center referral: Fax the following to 713.704.5922

- ☐ Gastrointestinal Oncology
- ☐ Hematology
- ☐ Medical Oncology/Lung
- ☐ Medical Oncology/Head and Neck/Thoracic Oncology
- ☐ Medical Oncology/Breast Oncology
- ☐ Medical Oncology/Multiple Myeloma, Lymphoma,
- ☐ Malignant Hematology, Leukemia
- ☐ Medical Oncology/Gynecological Oncology
- ☐ Oncology Diagnosis
- ☐ Osteosarcoma
- ☐ Palliative
- ☐ Surgical Breast Oncology
- ☐ Surgical Oncology
- ☐ Surgical Osteosarcoma
- ☐ Genetic Counseling
- ☐ Urological Oncology

REFERRING PHYSICIAN INFORMATION:

Date:________ Referring Physician: ____________________

Office Address: ____________________

City: ____________________ State:________ ZIP:__________

Office Phone: ____________________ Office Fax: ____________________

PATIENT INFORMATION:

Name: ____________________ Date of Birth: ____________

Address: ____________________

City: ____________________ State:________ ZIP:__________

Home Phone: ______________ Mobile Phone: ______________ Work Phone: ______________

HISTORY OF DIAGNOSIS:

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For physician referral preference: ____________________

Signature	Physician Print Name	NPI/MHHS ID.	Date	Time ☐ AM ☐ PM	Contact No.

Cancer Center Referral

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