ENLOE
REGIONAL CANCER CENTER

265 Cohasset Road
Chico, CA 95926
Phone: (530) 332-3936
Fax: (530) 893-6968

NEW PATIENT REFERRAL

Reason for Referral_____

☐ **Emergent** *(Within 24 hours)* ☐ **ASAP** *(Within 72 hours)* ☐ **Routine**

Please select the department(s) in which the patient needs to be seen:

☐ **Hematology/Oncology** ☐ **Surgical Oncology** ☐ **Genetics**
☐ **Radiation Oncology** ☐ **Comprehensive Breast Care/High Risk** ☐ **Lymphedema**

Preferred Provider *(if desired)*_____

☐ Schedule the patient to be seen by the next available provider in order to be seen in the time frame requested above.

PLEASE COMPLETE THE FOLLOWING INFORMATION:

Date of Referral_____ Patient Name_____

DOB_____ Patient Phone #_____

Referring Provider_____

Office Contact_____ Office Phone #_____

Name of patient's Primary Care Provider_____

Has patient been informed of referral? ☐ Yes ☐ No

Although not required, if possible please include the following to expedite care:

☐ Demographics ☐ Pathology Reports
☐ Last 2 Office Notes ☐ Lab Reports (Last 2 yrs.)
☐ Copy of Insurance Cards ☐ Radiology Reports
☐ Med List

FAX WITH YOUR OFFICE COVER SHEET AS PAGE ONE

Please FAX completed form and records to

New Patient Coordinator

Fax: (530) 893-6968 • **Phone:** (530) 332-3936