Cancer Center Palo Alto and Cancer Network
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 ☐Valley Care CAP ☐Emeryville

Date: _____
# of pages faxed _____

Stanford Referral Center
Phone: (877) 254-3762
Fax: (650) 320-9443

Referring Provider Information:

Referred by (MD):_____ Medical Group: _____

Phone:____ -_____ -_____ Fax:_____-_____ -_____

Address:_____ City:_____ Zip:_____

Primary Care Physician: _____ PCP Phone: _____-_____-_____

This form completed By:_____ Phone: ____-____-_____

Patient Information *(Please provide copy of patient demographics/face sheet)*:

Last Name:_____ First Name:_____ MI:_____

DOB:____/_____/____ Gender: Male / Female Phone:____-____-_____ Ht:_____ Wt:_____

Patient's Address:_____

City/State/Zip:_____ Needs Interpreter? Y / N Language:_____

Special Assistance? _____

Reason for Referral:

Diagnosis/ICD10:_____ Service /Specialty Requested:_____

Physician Requested:_____

Current Insurer: _____ Authorization Required? Y / N

Type of Service Requested:

Type of Visit:
☐ Clinic Consultation ☐2nd Opinion ☐Follow-up ☐Surgery ☐Clinical Trials ☐Tumor Board

All Relevant Documentation to Support Diagnosis *(Please fax with this form)*:

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

Additional Comments: