



Please send the completed form by emailing it to [ONCExtPtRecords@jpshealth.org](mailto:ONCExtPtRecords@jpshealth.org), faxing it to **817-702-8352** or calling a coordinator at **817-702-8300, ext. 6**. Make sure to include the original diagnoses documents:

- Pathology, radiology and lab reports
- Clinical notes
- Surgical reports
- Treatment summaries

Incomplete referral forms will be denied. Once the referral is processed, our staff will reach out to your patient to schedule an appointment.

**Patient Information**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Insurance Payor: \_\_\_\_\_ Group Number: \_\_\_\_\_

Patient's Phone Number: \_\_\_\_\_

**Referring Provider Information**

Provider's Name: \_\_\_\_\_ Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Office Email Address: \_\_\_\_\_ PCP Name (if known): \_\_\_\_\_

**Referral Information**

Date of Referral: \_\_\_\_\_ Reason for Referral: \_\_\_\_\_

Has the biopsy been done?    Yes    No                      Has surgery been done?    Yes    No

Name (of person submitting form): \_\_\_\_\_

Signature: \_\_\_\_\_

Date (MM/DD/YY): \_\_\_\_\_

