FLORIDA CANCER AFFILIATES

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Fax (850) 481-7050 *Oncology*
Fax (850) 481-7018 *Radiation*

□ **Andrew Weber, M.D.**
□ **Steven Finkelstein, M.D.**
□ **Christopher E. Haberman, M.D.**
□ **Steven Stokes, M.D.**

2614 Jenks Avenue
Panama City, FL 32405
Phone (850) 769-2996
Fax (850) 769-4665

□ **Syed K. Mahmood, M.D.**
□ **Kelly Carver, D.O.**

REQUEST FOR CONSULTATION

REFERRING PHYSICIAN INFORMATION

Date: __________________________

Referring Physician's Name: ____

Address: ____ Fax #: ____________________________________

Contact Name: ____ Phone #: _________________________________

MEDICAL INFORMATION NEEDED

Gender: □ Male □ Female DOB: ___________________

Name: First: ______________________ Middle: ____________________ Last: __________________________________

Phone #: ___________________________________ Cell #: _______________________________________

Primary Insurance: _____________________________ Secondary Insurance: _________________________________

If HMO: Referral#: _____________________________ Authorization: _________________________ Exp: ___________

REQUESTED APPOINTMENT

Reason for Referral, Symptoms and Diagnosis: *(Please be specific and state area of involvement)* ______________________

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Along with this referral, PLEASE fax demographic sheet and all insurance cards along with recent office notes, pathology reports including ER/PR and HER-2/neu, labs, all imaging reports including MRI's, CT scans, PET scans and ultrasounds.

Thank you for allowing us to participate in caring for your patient. We will contact the patient regarding this referral within 48 hours.

FLORIDA CANCER AFFILIATES USE ONLY

Chart#: ______________________________

New Patient Coordinator: ______________

Appointment Date: ___________________

Appointment Time: ___________________

Physician: ___________________________

Physician Initials: ___________

□Will see only with records

□Will see with records attached

□Scan prior to consultation

□Scan after consultation

Orders:

□CBC □CMP □PT/INR

Other:

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