McLaren-Greater Lansing
Thoracic Oncology Nurse Navigator Referral Form
[ ] Lung Cancer [ ] Esophageal Cancer

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Referral Request Form

Date of referral:_____

Request from:_____
(Physician's full name)

Phone:_____ Fax:_____

Patient Name:_____
(Last) *(First)* *(M)*

Address:_____City:_____Zip:_____

Home Phone:_____Work/Cell:_____

Diagnosis:_____

Indicate any testing patient has had regarding this diagnosis: (Please include reports if not performed at McLaren-GL)

[ ] CXR [ ] CT (chest) [ ] Bronchial Washings [ ] Biopsy [ ] MRI

[ ] PET [ ] CT (Abd/pelvis) [ ] EBUS/EUS Report [ ] EGD [ ] _____

Specific Needs / Requests / Comments:_____

_____

We honor physician preferences for managing their patient's care. Please indicate if any preference for the following:

Pulmonologist:_____

Gastroenterolgist:_____

Surgeon:_____

Medical Oncologist:_____

Services provided by the Nurse Navigator are to assist physicians in making certain the patient receives appropriate follow-up care, and are not intended to interfere in the physicians relationship with his/her patient, or to assume responsibility for obtaining such care.