



CANCER INSTITUTE
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PROTON THERAPY CENTER
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protontherapy@mclaren.org

4100 Beecher Rd., Flint, MI 48532

New Patient Referral

This form may be faxed or emailed with attention to the Patient Navigator.

Date: _____

Physician Referral Self-Referral

Branch you would like the patient to be evaluated (if applicable)?

Medical Oncology Surgical Oncology Radiation Oncology Proton Therapy

Patient Information

Name: _____

Address: _____ City: _____ State: ____ Zip: _____

DOB: ___/___/____ Sex: Male Female

SSN: ___ - ___ - _____

Primary Phone: (____) ____ - _____ Alternate Phone: (____) ____ - _____

Best time to call: _____ AM / PM

Contact Person (if not patient): _____ Relationship: _____

Contact Phone: (____) ____ - _____

Primary Physician: _____ Office Phone: (____) ____ - _____

Referral Information

Diagnosis/reason for referral: _____

Previous diagnosis of cancer: _____ Previous radiation treatment: Y / N

Surgeon: _____ Office Phone: (____) ____ - _____

Specialist: _____ Office Phone: (____) ____ - _____

McLaren Physician Requested: _____

Patient Insurance Information

**As of 11/18/2019 Meridian Health Plan is out of network and we cannot consult.

Primary: _____

Contract #: _____

Group #: _____

Secondary: _____

Contract #: _____

Group #: _____

Referring Physician Information

Referring Physician: _____

Address: _____ City: _____ State: ____ Zip: _____

Office Phone: (____) ____ - _____ Office Fax: (____) ____ - _____

Patient has been notified they are being referred to Karmanos Cancer Institute at McLaren Flint and/or McLaren Proton Therapy Center? Y / N

Additional Information Needed

- Pathology report (path slides will need to be requested**)
- Most recent scans – CT, PET, MRI, Bone Scan, etc. on CD in DICOM format along with reports**
- All labs
- Chart Notes
- Previous cancer treatment including chemotherapy flow and/or radiation flow sheets
- Surgical Oncologist: _____ Office Phone (____) ____ - _____
- Medical Oncologist: _____ Office Phone (____) ____ - _____
- Radiation Oncologist: _____ Office Phone (____) ____ - _____

**If Karmanos Cancer Institute at McLaren Flint and/or the McLaren Proton Therapy Center receives a signed Authorization to Release Medical Records form from the patient, we can request these items on the patient's behalf. This form is available on our websites: Karmanos Cancer Institute (www.karmanos.org/refer-patient) or McLaren Proton Therapy Center (www.mclaren.org/protonforphysicians). These forms may also be faxed or emailed to the patient or provider's office.

Self-Referral:

Are you a previous Karmanos or McLaren Proton Therapy Center patient? Y N

How did you hear about Karmanos and the McLaren Proton Therapy Center?

- | | |
|--|---|
| <input type="checkbox"/> Physician | <input type="checkbox"/> Radio |
| <input type="checkbox"/> Friend or Family Member | <input type="checkbox"/> Newspaper or Magazine |
| <input type="checkbox"/> Mail | <input type="checkbox"/> Online Ad |
| <input type="checkbox"/> Internet Search | <input type="checkbox"/> Billboard |
| <input type="checkbox"/> McLaren Website | <input type="checkbox"/> Community Event or Seminar |
| <input type="checkbox"/> Social Media | <input type="checkbox"/> Other: _____ |

Office Use Only

Scheduler: _____ Date: ____ / ____ / _____

Physician Assigned: _____

Scheduled Appointment Date & Time: ____ / ____ / _____ : ____ AM / PM