MSU/BRESLIN CANCER CENTER 401 W. Greenlawn, Lansing, MI 48910 (517) 975-9500 New Patient Referral Form

| Address Home Phone Cell Phone SS# | Date | Time | Taken E | By | _ MRN _ | |
|--|--|--|--|--|----------------|-------------------------|
| Patient Name | Referral Made To: | | No Phys | sician Specifi | ed | |
| Employer | Conley | Al-Janadi _ | Schwartz | Gulick | Tamkus | Aung |
| Address Home Phone Cell Phone SS# Employer Work Phone Emergency Contact Phone Diagnosis INSURANCE: (complete reverse side Referred By: Physician Patient Other Referring Physician (MD/DO) NPI # Address Contact Phone FAX Primary Care Physician (MD/DO) Phone Address Has the patient been hospitalized for the above diagnosis within the last 6 months? Y N Where? Please fax all records related to the above diagnosis to Breslin Cancer Center at (517) 334-2902. Records needed include: Copies of insurance cards Copy of most recent history & physical/dictated notes All recent x-rays, scans, and accompanying reports Copies of all pathology reports Recent laboratory reports Any pathology slides from any location outside of Lansing Chemotherapy records Copies of all operative reports Radiation therapy records Copies of all operative reports Radiation therapy records Insurance authorization form from primary care physician Appointment Date/Time Arrive At Attending/Fellow Scheduled/Approved By | Patient Name | LAGT | Emer | | Sex | DOB |
| Employer | | | | | W1.1. | |
| Emergency Contact | | | | | SS#_ | |
| Diagnosis | Employer | | | | Work Phone | 2 |
| Referred By:Physician | Emergency Contac | :t | | | Phone | |
| Referring Physician | Diagnosis | | | | INSURANCE | (complete reverse side) |
| Address | Referred By: | Physic | ian | Patient | | Other |
| Primary Care Physician | Referring Physicia | n | | (M | ID/DO) NF | PI# |
| Primary Care Physician | Address | | | | Contact | |
| Primary Care Physician | Phone | | | FAX _ | | |
| Has the patient been hospitalized for the above diagnosis within the last 6 months? Y N Where? | | | | (M | ID/DO) Phor | ne |
| Has the patient been hospitalized for the above diagnosis within the last 6 months? Y N Where? | Address | | | | | |
| Attending/Fellow Scheduled/Approved By | Where? Please fax all record Records needed ince Copies of ince All recent x Copies of a Recent labor Any patholochemothers Copies of a Radiation the Copies of a | rds related to the clude: nsurance cards ost recent history reasons, and pathology reports ogy slides from apy records apy records apy records any related discharged to the control of the cords any related discharged to the cords any related discharged to the clude of the cords and related to the clude of the cords and related to the clude of the clude o | e above diagnosis to y & physical/dictate and accompanying reports any location outside orts narge summaries | Breslin Canc d notes ports e of Lansing | | |
| | Appointment Date | /Time | | | Arrive A | At |
| Referring Physician Notified By Packet Sent | Attending/Fellow_ | | | Schedu | led/Approved B | у |
| | Referring Physicia | n Notified By _ | | | Packet Sent | |

| PRIMARY INSURANCE | | Effective Date | | Auth Req'd? | | |
|--|------------------------|--|-------------|-------------|---------|--|
| Name of Policyholder | | DOB | SS# | | | |
| Policyholder Address/Phone _ | | | | | | |
| Contract/Policy # | | Group # Ph | none # | | | |
| Copay | Deductible | Maximum | | | | |
| ****** | ******* | ********** | ***** | ****** | ***** | |
| SECONDARY INSURANCE | | Effective Date _ | | Auth Req'd? | | |
| Name of Policyholder | | DOB | SS# | | | |
| Policyholder Address/Phone _ | | | | | | |
| Contract/Policy # | | Group # Ph | none # | | | |
| Copay | Deductible | Maximum | | | | |
| OTHER INSURANCE | | DOB | DOB SS#_ | | | |
| Contract/Policy # | | | | | | |
| | | Maximum | | | | |
| ********** | | ************************************** | ***** | ****** | ******* | |
| Are you or your spouse c | currently working? | | | Yes | No | |
| If your spouse is working | g, does his/her medica | l coverage cover you? | | Yes | | |
| If you are working, do yo | ou have medical insura | ance through your company? | | Yes | No | |
| If you are not working, d | o you have another me | edical insurance? | | Yes | No | |
| In "Yes" is answered to a insurance must be billed | | ions, Medicare is secondary an | nd the pati | ent's prim | ary | |