MSU/BRESLIN CANCER CENTER
401 W. GREENLAWN, LANSING, MI 48910 (517) 975-9500
NEW PATIENT REFERRAL FORM

Date__________ Time _________ Taken By _________ MRN ____________________

Referral Made To: No Physician Specified _____

___ Conley ___ Al-Janadi ____ Schwartz ___ Gulick ___ Tamkus ____ Aung

Patient Name ______________________________________ Sex ____ DOB ____________
LAST FIRST M.I.

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 any related discharge summaries
____ Insurance authorization form from primary care physician

Appointment Date/Time ____________________________________ Arrive At ___________________

Attending/Fellow________________________________ Scheduled/Approved By ___________________

Referring Physician Notified By _________________________ Packet Sent ______________________
DATE DATE

PRIMARY INSURANCE ______________________________________ Effective Date ______________ Auth Req'd? _______

Name of Policyholder____ DOB ____________ SS#________________________

Policyholder Address/Phone ____

Contract/Policy #_____________________________________ Group #____________ Phone #__________________________

Copay ______________________ Deductible _________________________ Maximum ________________________________

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SECONDARY INSURANCE ______________________________________ Effective Date _____________ Auth Req'd? ______

Name of Policyholder____ DOB ____________ SS#________________________

Policyholder Address/Phone ____

Contract/Policy #_____________________________________ Group #____________ Phone #__________________________

Copay ______________________ Deductible _______________________ Maximum ______________________________

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OTHER INSURANCE ____ Effective Date _____________ Auth Req'd? ______

Name of Policyholder____ DOB _____________ SS#_______________________

Policyholder Address/Phone ____

Contract/Policy # ____________________________________ Group #_____________ Phone #_________________________

Copay ______________________ Deductible _______________________ Maximum _________________________________

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MEDICARE PATIENTS ONLY

Are you or your spouse currently working? ____ Yes ____ No

If your spouse is working, does his/her medical coverage cover you? ____ Yes ____ No

If you are working, do you have medical insurance through your company? ____ Yes ____ No

If you are not working, do you have another medical insurance? ____ Yes ____ No

In "Yes" is answered to any of the above questions, Medicare is secondary and the patient's primary insurance must be billed first.