DO NOT WRITE ABOVE THIS LINE

For CCOM Use Only:

NAME: _____
(last name, first name – please print)

MR# _____ DOB _____

Eastern Maine Medical Center
CancerCare of Maine

417 State St., Suite 20
Bangor, Maine 04401-6600
207-973-7478

New Patient Consultation Referral

Please complete this form entirely* and forward to CancerCare of Maine
Fax # **207-973-9457**

* All sections need to be completed before an appointment can be made.
This request will be reviewed by our physician staff. You will be called with the next available appropriate appointment.

Date of Referral: Doe, Jane	**Staff Completing Referral: Cindy**
Referring Provider: Dr. John Smith	Primary Care Provider (if different): Dr. Tom Jones
Phone Number: 207-555-5555	Fax Number: 207-555-5554

Patient Name: (Last, first – please print)
Doe, Jane

Date of Birth:
3/13/50

Social Security Number

EMMC MR if known
0000001

Address:
10 Somewhere Lane
Brewer ME

Phone Number:
207-555-4444

Insurance
Primary _____Cigna_____
Contract # 111111 Group# 2222
Secondary _____
Contract # _____ Group# _____
Medicare Part D _____
☐ FAX insurance referral (non-Medicare)

Please fax the following information
with referral **if NOT** available in EMMC's PowerChart
☐ All information except office notes in PowerChart
☑ H & P, D/C Summary
☑ Operative Notes
☑ Office Notes (Please include, if any, outside referral info received)
☑ Lab Reports
☑ Pathology Reports
☑ Imaging reports
☑ Image Films – to be hand carried if not on PACS system
☑ RT Records & Simulation films
(For continuing RT/ new when RT previously provided @ another facility)
☐ Genetics – do **NOT** send records, see details attached
☐ Other information being sent (please identify)

Reason for Referral:
Breast CA

Referring to -
X Medical Oncologist ☐ Radiation Oncologist
☐ Hematologist ☐ Cancer Genetics
☐ MD spoke with _____, MD on _____

Recent **Surgery / Biopsy**

Date	Specify site & procedure	Location:
1/5/19	Ultrasound guided biopsy	NL EMMC
1/25/	Left Mastectomy	NL EMMC

Recent **imaging/diagnostic studies/labs**

Date	Study	Location
12/12/18	Mammogram	DECH
12/19/19	Ultrasound Breast	DECH

Previous / Current **Chemotherapy** Yes X No
If YES, Date Location

Previous / Current **Radiation Therapy** Yes X No
If Yes, Date Location

CCOM Use Only

Referral to MD (date):
Returned (date):

Appointment Date/Time/MD:
☐ **MO** –
☐ **RO** –

Appt scheduled by:

Referring Office notified (date/time):

☐ Packet Sent ☐ Pt Called

Additional CCOM MD orders:

MD Review – ☐ next available ____weeks ____ months
Please return records with this form ☐ **Records returned**

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