Stanford HEALTH CARE
STANFORD MEDICINE

Cancer Center Palo Alto and Cancer Network Referral Request Form

Thank you for choosing Stanford Health Care. We look forward to partnering with you in your patient's care. Please note which location this is for:

Palo Alto South Bay Redwood City

Date: _______________
# of pages faxed ________

Stanford Referral Center
Phone: (877) 254-3762
Fax: (650) 320-9443

Referring Provider Information:

Referred by (MD):________________________ Medical Group: _______________________________

Phone:__________________ Fax:______________________

Address:__________________________________ City:_______________ Zip:__________________

Primary Care Physician: ___________________________________ PCP Phone: ________________

This form completed by:___________________________________ Phone: ____________________

Patient Information *(Please provide copy of patient demographics/face sheet)*:

Last Name:________________________ First Name:_________________________ MI:_______

DOB:____/_____/____ Gender: Phone:________________ Ht:_____ Wt:_____

Patient's Address:______________________________________ City:__________________________

State: _______ Zip:___________ Needs Interpreter? ____ Language:_____________

Special Assistance? ____

Reason for Referral:

Diagnosis/ICD10:_______________________ Service/Specialty Requested:_____________________

Physician Requested:____

Current Insurer: _____________________________________ Authorization Required?

Type of Service Requested:

Type of Visit:
Clinic Consultation 2nd Opinion Follow-up Surgery Clinical Trials Tumor Board

All Relevant Documentation to Support Diagnosis *(Please fax with this form)*:

- Tumor Board
- Clinical Trials
- Genetic / Molecular Testing
- Lab Reports
- Imaging Reports
- Chemotherapy Treatment Records
- Pathology (biopsy results)
- Radiation Oncology Results
- Operative Reports for Cancer Surgeries

Additional Comments: