Karmanos CANCER INSTITUTE
tel (810) 342-3800 • fax (810) 342-3784
kcnflint@mclaren.org

McLaren PROTON THERAPY CENTER
tel (810) 342-3840 • fax (810) 342-4229
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?

☐ Physician

☐ Friend or Family Member

☐ Mail

☐ Internet Search

☐ McLaren Website

☐ Social Media

☐ Radio

☐ Newspaper or Magazine

☐ Online Ad

☐ Billboard

☐ Community Event or Seminar

☐ Other: _____

Office Use Only

Scheduler: _____ Date: ____ / ____ / _____

Physician Assigned: _____

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