NEW PATIENT INFORMATION CHECKLIST MEDICAL ONCOLOGY
CLI.2072

DATE OF REFERRAL: _____ Diagnosis: _____

REFERRAL TAKEN BY: _____

RECORDS RECEIVED BY: _____

Patient Name_____ DOB _____ SS #: _____

Address _____

Telephone # _____ Insurance _____ VA Auth # _____

Referring Physician _____ Telephone # _____

Address _____FAX # _____

All tests obtained at Adena Health System? **Y** **N**

If Yes – schedule appointment. If No, where are records? Complete checklist below.

Checklist of Records Needed:

_____ Demographic / Insurance Info

_____ X-Ray Reports & Films / Imaging / Discs

_____ Pertinent Office Note

_____ Operative Notes

_____ Pathology Report

_____ Recent Labs / Pertinent Labs

_____ Advance Directives

_____ Genetics

_____ Survivorship

** Patient seen at Adena Oncology / Cancer Center prior? **Y** **N**

If Yes, with Dr. _____. What date? _____

Appointment Scheduled – Date_____ Dr. _____

Arrival Time _____

Clinic contacted with Appointment Date and Time for patient notification **Y** **N**

NOTES:
Primary Care Provider _____

Providers seen within last 12 months: