NEW PATIENT INFORMATION CHECKLIST RADIATION
CLI.2072

DATE OF REFERRAL: ____________________ REQUESTED SERVICES:
Diagnosis:______________________________ RAD ONC ________ MED ONC_______

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 Films / Imaging / Discs

_____ Pertinent Office Note

_____ Operative Notes

_____ Pathology Report

_____ Recent Labs / Pertinent Labs

_____ Prior Cancer Treatment Records

Appointment Scheduled – Date_____________________________________ Dr. ______________________

Arrival Time ___________________________

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

NAVIGATORS NOTIFIED:

GI ___________

Head & Neck ___________

Breast ___________

Lung ___________

NOTES:

Primary Care Provider: ___________________________

Providers seen within last 12 months: