UL Health | Brown Cancer Center

☐ Brown Cancer Center – Downtown
☐ Brown Cancer Center – Northeast
☐ Brown Cancer Center – Bluegrass

OUTPATIENT ONCOLOGY REFERRAL

*All Fields are Mandatory

To Be Scanned
Hope Line Phone: (502) 562-4673
Hope Line Fax: (502) 217-5031
Email: hopelinereferrals@uoflhealth.org

Records Needed for Referral: Email or fax records to 502-217-5031 **Insurance Card** **Photo ID** **Last 3 Office Notes** **Diagnostic Imaging** **Pathology/Biopsy Report** **Labs** **Chemo Flow Sheet/Orders** **Radiation Dosimetry/Completion Note** **Operative Report**

Records Faxed/Emailed By Caller: **Phone#:**

Records Available in EPIC: ☐ **BAPTIST** ☐ **NORTON** ☐ **ULP** ☐ **CERNER** ☐ **RECORDS HERE**

Nurse Navigator: **Hopeline/Intake:**

Diagnosis: **Cancer Type:**

***SPECIALTY REQUESTED**

☐ Bone Marrow Transplant (leukemia, lymphoma) ☐ Hematology ☐ Medical Oncology ☐ Radiation Oncology ☐ Surgery

***REFERRAL REASON**

☐ New Diagnosis ☐ Second Opinion/Self-Referral ☐ Continuation of Care, new to area ☐ Radiation Oncology ☐ Surgery

Requested Provider: **Appt Needed:** ☐ **Routine** ☐ **Urgent**

*PATIENT INFORMATION

Name (Last, First Middle):
Address:
City: State: Zip:
Email Address:
Emergency Contact: Relationship:
Phone: Verbal Permission: ☐ YES ☐ NO

DOB:
SSN:
SEX:
HOME:
CELL:
ULH MR#:
INTERPRETER: ☐ **Yes** ☐ **No**
Language:

*REFERRING OFFICE

Referring Provider:
Address:
City State: Zip:

DATE:
OFFICE#:
FAX#:
CALLER:

*PRIMARY CARE PROVIDER OFFICE

Primary Care Provider:
Address:
City State: Zip:

OFFICE#:
FAX#:

*INSURANCE INFORMATION

PRIMARY INS CO:	Subscriber Name:
Plan Type:	Subscriber ID#:
Phone #:	Group ID#:
SECONDARY INS CO:	Subscriber Name:
Plan Type:	Subscriber ID#:
Phone:	Group #:

ADDITIONAL PROVIDERS

Additional Provider: Address: City State: Zip:	**OFFICE#:** FAX#:
Additional Provider: Address: City State: Zip:	**OFFICE#:** **FAX#:**
Additional Provider: Address: City State: Zip:	**OFFICE#:** **FAX#:**

HOSPITALS

Hospital: Address: City State: Zip:	**HOSPITAL#:** **FAX#:**
Hospital: Address: City State: Zip:	**HOSPITAL#:** **HOSPITAL FAX#:**
Hospital: Address: City State: Zip:	**HOSPITAL#:** **HOSPITAL FAX:**

Additional Information:

Patient Appt Date / Time / Provider: