

Referral Form

Thank you for choosing UC Davis for your patient's medical needs. To initiate the referral process, please **FAX** this form to the UC Davis Comprehensive Cancer Center at **(916) 703-5266**.

- Include pertinent medical records, including test results/pathology that supports the consultation only.

- Upon review and approval, we will then schedule an appointment with the patient.
- If you require additional assistance, please call **(916) 734-5959 opt 1** to speak to a Referral Coordinator.
- Please note any missing or incomplete referral will be returned to the referring office to be completed.

Please Print Clearly

Date:	From:
No. of pages:	Title:
To UC Davis Practice:	Phone: Fax:

Patient Information

Name of patient:		SSN/UC Davis MRN (optional):	
Date of birth:	Sex:	Interpreter needed: ☐ Yes ☐ No	Language:
Home phone number (with area code):		Work/cell phone:	
If child, name of parent:			
Address:			
City:		Zip:	

Patient Insurance

Insurance: Include patient's insurance card (both sides) and HMO authorization if required CPT Code 99245 x1, 99215 x3, 88321 x1, and 99205 x1

Insurance name/type:	ID number:	Group number:	Authorization number/Status:	Subscriber:

Consultation Request Information

Diagnosis/ICD 10:	
Name of UCD MD (if known):	Specialty:
Reason for consultation:	

Referring Physician Information

Referring MD:	Specialty:
Phone:	Fax:
PCP name:	Phone:

Internal Use Only

Delivered by:	Date:	Triaged By:	Date:
Approved Service:		Provider Specified:	

NOTICE OF CONFIDENTIALITY: This is a confidential fax and is intended solely for the person indicated above. If you are not the intended person, you are hereby notified of the confidential nature of this fax and that you are not entitled to read, copy, or otherwise disseminate any of the information contained herein.