OSF HealthCare Cancer Institute

1310 N Missouri Ave
Peoria, IL 61603
Phone: (309)624-5151

Fax completed referral and records to: **309-717-0458**

PATIENT INFORMATION

Patient Name:_____ DOB: _____

Sex: ☐ M ☐ F Phone: _____ Alternative Phone: _____

Alternative Contact Person & Number: _____

Address: _____

☐ **CANCER SUPER REFERRAL**

For suspected or confirmed cancer diagnoses

By selecting this option, you confirm understanding that an RN will perform a clinical review and facilitate appropriate cancer services and referrals based on clinical findings.

REFERRAL DETAILS

☐ Suspicion of Cancer ☐ Confirmed Cancer ☐ Other: _____

REQUESTED SERVICES:

☐ Consult / Second Opinion	☐ Surgical Oncology
☐ Treatment	☐ Hem/Med Oncology
☐ Navigation	☐ Cancer Support Services
☐ Clinical Trials	☐ Radiation/Proton
☐ Surveillance / Follow-Up	☐ Unknown
☐ Other: _____	

CANCER TYPE / SITE:

☐ Breast	☐ Gyn
☐ Lung	☐ Head & Neck
☐ GI	☐ Brain / Spine
☐ GU	☐ Metastatic
☐ Melanoma / Skin	☐ Unknown
☐ Liver / Pancreas	☐ Other: _____

Please note: *Medical Oncology is currently accepting referrals for GI, Melanoma, and Lung diagnoses only.*

Reason for Request/Diagnosis (ICD-10): _____

REFERRING PROVIDER

Provider Name:	Facility:
Office Phone:	Office Fax:
Office Contact Person and Ext:	
Signature: _____ Date: _____	

REQUIRED DOCUMENTATION

☐ Provider Notes ☐ Labs/Imaging ☐ Insurance

☐ List of Medications (include OTC and herbs/supplements) ☐ Allergies