



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

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