

RAPID REFERRAL FORM

Date: ____ / ____ / ____

From: _____ Routine Urgent

Sender's Fax #: _____ Sender's Phone #: _____

TO REFER OR SCHEDULE A NEW PATIENT:

1. **EMAIL** this form to the email addresses listed below and include all pertinent records:
shenandoahreferrals@usoncology.com

2. **FAX** this form to the number listed below and include all pertinent records:
Medical Oncology/Hematology
540.450.1791

Radiation Oncology
540.722.2635

Genetics
540.446.2800

PATIENT PROFILE

Demographics sheet attached? yes no (If yes, please be sure all information below is included.)

Patient Name: _____ DOB: ____ / ____ / ____ Sex: M F
Last First MI

Patient Address: _____
Street City Zip

Home Phone: () _____ Cell Phone: () _____

Social Security Number: _____ Place of Employment: _____

Race: _____ Language preferred: _____

REFERRING PHYSICIAN INFORMATION

Referring Physician: _____ NPI: _____

Diagnosis: _____ (Please note: Diagnosis is needed to obtain referral if required by insurance)
(i.e. cancer type, heme, ICD-10 code, other)

INSURANCE

Primary Carrier: _____ Subscriber Name: _____

Policy #: _____ Subscriber DOB: ____ / ____ / ____

Secondary Carrier: _____ Subscriber Name: _____

Policy #: _____ Subscriber DOB: ____ / ____ / ____

In order for our physician to provide you and your patient with the best possible consultation, we will need the following medical records PRIOR to scheduling the appointment:

- Lab results (up to 6-12 months if available)
- Colonoscopy (for all patients if available)
- Endoscopy (for all patients if available)
- Office visit notes (last 2-3 visits)
- Imaging related to the diagnosis
- Pathology related to the diagnosis
- Operative notes related to the diagnosis



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