GYNECOLOGIC ONCOLOGY REFERRAL FOR CONSULTATION

1700 6th Avenue South – WIC 10th Floor Birmingham, Alabama 35233
Tel: 205-996-4662 Fax: 205-996-2886

☐ First Available ☐ Requested Priority: _____ ☐ Requested MD: _____

Patient Name: _____ DOB: _____

Address: _____

City, State, ZIP: _____

Patient's email address: _____

Primary Phone #: _____ Alternate Phone #: _____

Emergency contact/phone #: _____

Insurance Company: _____ Name of insured: _____

Policy #: _____ Group #: _____ Pre-certification/referral #: _____

*Insurances requiring referral include: Cigna Health Springs, Humana Gold, Tricare, Medicare Complete, Aetna

Referring Physician: _____ Office Contact: _____

Office phone: _____ Fax: _____

Diagnosis prompting consultation: _____

_____

_____

Will your patient require special assistance during her visit? (please specify, i.e. interpreter, wheelchair, financial, social work, etc.)

_____

GYN ONC SERVICES REQUESTED

☐ Consultation

☐ Surgical Consultation

☐ Chemotherapy/radiation

☐ Clinical Trial Evaluation

☐ Comprehensive Ovarian Cancer Program

☐ Cervical Cancer Program

☐ Gyn Onc Genetics Program

Pertinent medical records such as labs, last clinic note, operative notes, imaging studies (CT/US/PET), pathology reports, genetic testing results, Pap smear results (most recent), and copy of insurance card must be included with this referral form. Appointment confirmation will be faxed to your office within 24 hours of receipt of this form and medical records. Please fax appropriate records to 205-996-2886. If you have any questions **or need immediate assistance**, please call **205-996-4662. Please have the patient bring copies of imaging studies on CD to the appointment**. Thank you.

Rebecca Arend, MD
Warner Huh, MD
Charles Leath, MD
Micheal Toboni, MD
Haller Smith, MD
Michael Straughn, MD