

**CLINICAL TRIALS
Physician Referral Form**

FAX: 480-882-5820
ATTN: Joyce Schaffer MSN RN OCN

Virginia G. Piper Cancer Center
Clinical Trials
10510 N. 92nd Street, Suite 200
Scottsdale, AZ 85258
480-323-1339
joschaffer@shc.org

DATE OF REQUEST: ___ / ___ / ___

REFERRING PHYSICIAN: _____ **NPI#** _____

MAIN OFFICE # _____ **FAX #** _____

PATIENT NAME: _____ **DIAGNOSIS:** _____

DOB: ___ / ___ / ___ **PATIENT CONTACT #** _____

Please provide the following records:

- **Original pathology report and any subsequent pathology reports**
- **Treatment records - including specific drugs, dosages and dates - both chemo and radiation**
- **Treating physicians last two dictated office visit notes – including detailed History & Physical**
- **Report of baseline and most recent scans/x-rays**
- **Report of latest lab work.**
- **Insurance information (copies of front and back of card)**
- **Demographics (full name; address & phone: SS#)**

We will contact the patient and schedule an appointment upon receipt of the above information.
Thank you for the referral.