

Scottsdale Healthcare Research Institute

Physician Referral Form

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Scottsdale Healthcare Research Institute
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DATE OF REQUEST: ___ / ___ / ___ **REFERRING PHYSICIAN:** _____

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.

