Cancer Center of
Western Wisconsin

NEW CONSULT

Fax Completed Form to 715-243-2801

☐ Oncology ☐ Hematology

Date: _____ Name of person completing form: _____

Phone Number: _____ Fax Number: _____

Patient Information

Patient's Name: _____ Date of Birth: _____

Home Phone Number: _____ Cell Phone Number: _____

Check the appropriate box if it is okay to leave messages on these voice mails. ☐ Yes ☐ No

Insurance (name on card): _____ Group #: _____

ID#: _____

Diagnosis for Referral: _____

_____

Referring Physician

_____ _____
Name Clinic

_____ _____
Phone Number Address

_____ _____
Fax Number City, State Zip

Primary Physician

_____ _____
Name Clinic

_____ _____
Phone Number Address

_____ _____
Fax Number City, State Zip

Please attach the following documents:

- Most recent H&P from primary MD
- Operative or Surgical Reports
- Pathology Reports
- Current medication list/allergies
- Dictations or notes
- Procedures/labs/imaging (CT, PETCT, Ultrasound, MRI) (last 6mos)
- All history pertaining to cancer or hematology diagnosis
- Demographic/Face sheet

Partnering Organizations Amery Regional Medical Center • Baldwin Area Medical Center • Hudson Hospital & Clinics
Osceola Medical Center • St. Croix Regional Medical Center • Westfields Hospital
Radiation Therapy Center of Western Wisconsin