



# Foley Cancer Center

A Department of Rutland Regional Medical Center

160 Allen Street, Rutland, VT 05701 | www.RRMC.org | 802.747.1831 | Fax 802.747.1826

## OUTPATIENT / INPATIENT REFERRAL FORM

DATE \_\_\_\_\_ MD REQUESTED \_\_\_\_\_

REF. MD \_\_\_\_\_ PRIMARY MD \_\_\_\_\_

CONTACT PERSON \_\_\_\_\_ PHONE # \_\_\_\_\_

INPATIENT \_\_\_\_\_ ROOM# \_\_\_\_\_ BED# \_\_\_\_\_

### PATIENT INFORMATION

NAME \_\_\_\_\_ DOB \_\_\_\_\_ SEX \_\_\_\_\_ MRN \_\_\_\_\_

SS \_\_\_\_\_ TELEPHONE (H) \_\_\_\_\_ (W) \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_

DIAGNOSIS: \_\_\_\_\_

HOW SOON MUST PATIENT BE SEEN? \_\_\_\_\_

INSURANCE NAME \_\_\_\_\_ MANAGED CARE  YES  NO

### IMPORTANT INFORMATION

#### **Insurance: United Health Care (HMO) – Aetna – Medicare Advantage – AARP**

Because of the above-referenced insurance's new guidelines, a referral from the patient's primary care physician to the insurance company needs to be submitted prior to sending this referral in order for this referral to be completed. Please take the time to send the requested referral at your earliest opportunity and attach a copy with this referral request.

RRMC LAB  YES  NO OTHER LAB  YES  NO NAME \_\_\_\_\_

RECENT SURGERY:  YES  NO

SURGERY DATES \_\_\_\_\_ SITE \_\_\_\_\_

RECENT STUDIES (XRAY, PATHOLOGY) \_\_\_\_\_

Outside film Information \_\_\_\_\_

COMMENTS: \_\_\_\_\_

ADDITIONAL M.D. ORDERS \_\_\_\_\_

**Appointment Date:** \_\_\_\_\_

**Appointment Time:** \_\_\_\_\_

**Appointment Confirmed By:** \_\_\_\_\_