



Liver Cancer Referral Form

Date: ___/___/___

To begin our assessment the following information is **required**. Please use the form to ensure **ALL REQUIRED** documents are received. Please send the patient's records and demographics (**including a copy of driver's license and insurance card**). The required information and financial clearance must be received **before referrals are processed**. Please fill out form entirely. **Any incomplete or missing information will result in the referral being delayed.**

Patient Information : Name (Mr/Mrs, First-middle-last, Jr/Sr) : _____

Language: _____ Race: _____ Ethnicity: _____ Gender: M F SSN#: _____

Address: _____ City _____ State _____ Zip _____

Phone#: (_____) _____ DOB: _____ Age: ____

Reason for referral: _____ **Diagnosis:** _____

******REQUIRED CLINICAL INFORMATION TO PROCESS THIS REFERRAL******

- Recent H&P and Progress Notes
- Specialist Consultations, and Pathology Reports
- CBC / CMP / INR / AFP (current labs, and labs done within the last year)
- X-Ray Reports: CT / MRI (patient to bring CD of x-rays to initial visit)
- EGD report and biopsy results
- Colonoscopy report and biopsy results
- Abdominal operative reports
- List of current medications

Referring MD: _____ **Specialty:** _____

Address: _____ City _____ State _____ Zip _____

Phone #: (_____) _____ FAX #: (_____) _____ Contact Person: _____

PCP: _____ **Address:** _____

Phone# (_____) _____ FAX#(_____) _____

Insurance Information: If patient has HMO plan, they must provide copy of referral authorization prior to first appointment.

Insurance Co #1: _____	Insurance Co #2: _____
Insured: _____	Insured: _____
Insured DOB#: _____	Insured DOB#: _____
Policy#: _____	Policy#: _____
Group#: _____	Group#: _____
Phone# _____	Phone# _____

Has the insurance company been notified of referral? YES NO Authorization #: _____

PLEASE FAX INFORMATION TO: TGMG Case Management Department
409 Bayshore Blvd Tampa, FL 33606
Phone: (813) 844-5507
Fax#: (813) 844-1921

FOR OFFICE USE ONLY

MR#: _____

Referral#: _____

Comments: _____

