

# Surgical Oncology Referral Form

UT Medicine (fax): 1-512-232-3899  
Surgical Oncology (fax): 1-512-495-5709

**Patient information**

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Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Address: \_\_\_\_\_ Day phone: \_\_\_\_\_  
Alt. phone: \_\_\_\_\_  
Preferred language: \_\_\_\_\_

**Insurance/authorization information**

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Insurance name: \_\_\_\_\_ Secondary insurance name: \_\_\_\_\_  
Policy #: \_\_\_\_\_  
Authorization # (if required): \_\_\_\_\_ Policy #: \_\_\_\_\_  
Authorization #: \_\_\_\_\_

**Referring physician information**

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Name of referring physician: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Fax: \_\_\_\_\_  
PCP: \_\_\_\_\_

**Refer to provider and specialty**

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Referring to provider name: \_\_\_\_\_

Reason for referral (for oncology referrals please include diagnosis, stage and grade): \_\_\_\_\_

Primary/billing diagnosis: \_\_\_\_\_

**\*Please send all pertinent records related to the care you are requesting\***

**Clinical information/comment(s):** \_\_\_\_\_

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