Memorial Hermann Texas Medical Center
Texas Medical Center Cancer Center Referral Form

Please fax this form, along with patient medical records, including labs, imaging reports, procedure reports, medication lists (including chemotherapy) and patient demographics to 713.704.5922. For any questions, please do not hesitate to contact our office at 713.704.2833.

Reason for Cancer Center referral: Fax the following to 713.704.5922

- ☐ Gastrointestinal Oncology
- ☐ Hematology
- ☐ Medical Oncology/Lung
- ☐ Medical Oncology/Head and Neck/Thoracic Oncology
- ☐ Medical Oncology/Breast Oncology
- ☐ Medical Oncology/Multiple Myeloma, Lymphoma,
- ☐ Malignant Hematology, Leukemia
- ☐ Medical Oncology/Gynecological Oncology
- ☐ Oncology Diagnosis
- ☐ Palliative
- ☐ Sarcoma
- ☐ Surgical Breast Oncology
- ☐ Surgical Oncology
- ☐ Surgical Osteosarcoma
- ☐ Genetic Counseling
- ☐ Urological Oncology

REFERRING PHYSICIAN INFORMATION:

Date:_____ Referring Physician: _____

Office Address: _____

City: _____ State:_____ ZIP:_____

Office Phone: _____ Office Fax:_____

PATIENT INFORMATION:

Name:_____ Date of Birth:_____

Address: _____

City: _____ State:_____ ZIP:_____

Home Phone: _____ Mobile Phone:_____ Work Phone:_____

DATE AND HISTORY OF DIAGNOSIS:

_____

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For physician referral preference: _____

☐ I, referring provider, attest that I have discussed this referral with the patient, and the patient has provided consent to the sharing of their demographic and contact information with Memorial Hermann or its affiliated providers for the purposes related to this referral, including: (1) telephone calls and text messages regarding health care, including but not limited to scheduling, reminders, and medication refills; (2) email or mail communications regarding health care, including but not limited to scheduling, reminders, and medication referrals; and (3) other information regarding my health care, billing and health related services and benefits. I have instructed the patient if they wish to revoke this consent, they may contact Memorial Hermann at 713-222-CARE (2273) or opt out directly after receipt of communication.

Provider Signature	Print Name	NPI/MHHS ID.	Date	Time ☐ AM ☐ PM	Contact No.

MEMORIAL HERMANN

Cancer Center Referral

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