

# CONFIDENTIAL

Phone: 912-354-6187 & Fax 912-691-9231

Attention: New Patient Referrals



## SAVANNAH LOCATION

Ronald F. Goldberg, MD; Grant C. Lewis, MD; Barry L. Luskey, MD; L. E. Robertson, MD;  
Alison E. Spellman, MD; Mark A. Taylor, MD; Stephen A. White, MD

## STATESBORO LOCATION

Ronald F. Goldberg, MD; Grant C. Lewis, MD; L. E. Robertson, MD FACP

## BLUFFTON LOCATION

Kathy L. Christman, MD

**LOCATION**    ☐ Savannah    ☐ Statesboro    ☐ Bluffton

**SCHEDULE**    ☐ First available    ☐ Stat 2-3 days    ☐ 7-10 days

Reason for referral to include diagnosis \_\_\_\_\_

Patients name \_\_\_\_\_

Date of birth \_\_\_\_\_ Social security number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Referring Physician \_\_\_\_\_ Phone \_\_\_\_\_

Referring Physician contact \_\_\_\_\_ Fax \_\_\_\_\_

The consultation will be scheduled with any physician at the requested location. If you prefer a specific physician please specify and we will try to accommodate your request. A mandatory request for a specific physician requires a physician to physician phone call. Thank you for your cooperation.

*Please include a copy of the insurance card(s) and demographic sheet. Please include the full social security number of the insured. If the insurance requires a referral or authorization you must include it in your paperwork or the appointment will not be scheduled.*

If Malignancy Related Diagnosis: Previous biopsy or surgery?    ☐ Yes    ☐ No

**ALL PERTINENT REPORTS MUST ACCOMPANY THE REFERRAL FOR ALL APPOINTMENT TYPES OR THE APPOINTMENT WILL BE DELAYED**

Has the patient seen an Oncologist?    ☐ Yes    ☐ No    Recent radiologic studies?    ☐ Yes    ☐ No

### REQUESTED ITEMS TO BE FAXED

- New Patient Referral Form
- Insurance Card(s)
- Referral/Authorization
- Medical records including any pathology, lab work and diagnostic imaging reports

### For SJ/C Summit Cancer Care Use Only

Date Referral received \_\_\_\_\_ Date completed \_\_\_\_\_ Received Ins Card \_\_\_\_\_

Appointment Date \_\_\_\_\_ Physician scheduled \_\_\_\_\_ Received Ref/Auth form \_\_\_\_\_

Appointment Time \_\_\_\_\_ Initials \_\_\_\_\_ Received Records \_\_\_\_\_