

REFERRAL FAX COVER SHEET



DATE: _____ TO: CYBERKNIFE CENTER – LOUISIANA

FAX: 337-289-8071 # OF PAGES (INCLUDING THIS PAGE) _____

FROM: _____ PHONE: _____

REFERRING PHYSICIAN: _____

PLEASE NOTE

In order for your patient to be reviewed at the current week's case conference, all information must be submitted by noon on Thursday of the current week. Anything submitted after deadline will be reviewed at the next week's conference unless it is deemed an emergency.

Please submit the following information to us (if applicable) and join us for the next case conference:

- | | |
|---|---|
| <input type="checkbox"/> Patient Info / Demographic Sheet | <input type="checkbox"/> Operative Report |
| <input type="checkbox"/> Insurance Card(s)* | <input type="checkbox"/> Pathology Report |
| <input type="checkbox"/> Diagnosis: _____ | <input type="checkbox"/> Previous Radiation Report |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Radiology Reports AND actual images on CD/Film
(Call for courier to pick up or mail actual films to the Center) |
| <input type="checkbox"/> Last Consult/Follow-up Summary | <input type="checkbox"/> Labs |
| <input type="checkbox"/> Medication List | |

Referral Process: Following a multidisciplinary CyberKnife team review of the above, you will be notified if your patient is a candidate and if the patient has been set up for consult appointments. Most patients are treated by a CyberKnife-trained radiation oncologist AND a surgeon, so two consults may be required. All efforts are made to schedule appointments on the same day, especially if the patient does not reside within 20 miles of the Center and/or if the patient needs transportation.

*Medicare, Medicaid and most major insurances cover the procedure.

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