FAX COMPLETED FORM
TO: 608-251-4255

Request for
Radiation Oncology
Consult Form

ORDER DATE: ______________________________

Referring Physician: ______________________________ Completed By: ______________________________

Referring Physician Phone #: ______________________________ Fax #: ______________________________

Patient: ______________________________
(Last Name) (First Name) (Middle Initial)

Sex: __________ DOB: __________ Age: __________

Home Phone: ______________________________ Work Phone: ______________________________

Home Address: ______________________________
(Street) (City, State) (Zip)

Primary Insurance: ______________________________ Secondary ?: ______________________________

AREA WE ARE TREATING: ______________________________

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PRIMARY SITE: ______________________________

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Appointment Time Frame (circle one): ASAP Next Available 1–2 weeks

Is the patient expecting our call? YES NO

Films? YES NO If YES, Location: ______________________________

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Special Instructions: ______________________________

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