



▲ United in Healing with The US Oncology Network

Referring Physician Information

Referring Physician's Name: _____

Referring Physician Phone: _____ FAX: _____

Referring Physician Email: _____

Referred Patient Information

Patient Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Patient Phone Number: _____

Patient Date of Birth: _____

Oncologist Information

Please set an appointment with:

- | | |
|--|--|
| <input type="checkbox"/> First Available Physician | <input type="checkbox"/> Deborah Lindquist, MD – Sedona |
| <input type="checkbox"/> Paul Kuefler, MD – Flagstaff | <input type="checkbox"/> Pamela Miel, MD – Cottonwood, Prescott Valley |
| <input type="checkbox"/> Peter Mathern, MD – Flagstaff | <input type="checkbox"/> Michael Vu, MD, PharmD – Prescott Valley |

Preferred Appointment Date or Day of the Week: _____

Reason for Consult: _____

Please send the following medical records to our practice prior to the patient's appointment.

Hematology:

- One year or more of lab results
- Referring MD chart notes pertaining to referral diagnosis

Oncology ALSO include:

- Labs completed in the last two years
- Diagnostic studies completed in the last two years
- Hospital admitting history and physical
- Hospital discharge summary
- Pathology Reports (ER-PR HER-2 for Breast Patient)
- Operative reports