Prem Raja, MD Brian Plants, MD	**CAMC Radiation Oncology** 3415 MacCorkle Avenue S.E. Charleston, WV 25304 Phone: (304) 388-1790 Fax: (304) 388-1795	Lloyd Farinash, MD Joel Grow, MD

*****PLEASE FAX THIS FORM TO (304) 388-1795*****

Patient Information

First Name: ______________________ M.I.: ___ Last Name: ______________________

D.O.B.: _____ / _____ / _____ SSN: _______ - _______ - _______ Marital Status: S M W D

Address: ____

City: ____________________ State: _______ Zip Code: _______ Home Phone: ______________

Secondary Contact: ______________________________ Contact Phone: ______________

Referring Physician Information

Referring Physician Name: ______________________________ NPI#: ____________________

Address: ____

City: ____________________ State: _______ Zip Code: _______

Office Phone: ____________________ Fax: ____________________ Contact Person: ______________

Referring Diagnosis and Reason For Referral: ______________________________

Insurance Information

Insurance Carrier: ____
(COPIES OFCARDS ***MUST*** BE FAXED)

Insurance ID: ____________________ Authorization#: ____________________ # of Visits: _____

*****The Following Information *MUST* Be Provided for an Appointment to be Made*****

Please clarify that the patient has agreed to be seen at our facility and thank you for referring your patient to CAMC Radiation Oncology.

- Doctor/Progress Notes
- H&P
- Operative/Pathology Reports
- Laboratory Reports
- Radiology Reports

DO NOT WRITE BELOW – OFFICE USE ONLY

Appointment Scheduled With: □ Dr. Raja □ Dr. Farinash □ Dr. Plants □ Dr. Grow

Appointment Date: ____________________ Time: ______________