



**NORRIS COTTON
CANCER CENTER**

a component of

**DARTMOUTH-HITCHCOCK
MEDICAL CENTER**

DHMC use only

Appt. Date: _____

Appt Time: _____

PH#: (603) 650-6344

**Comprehensive Thoracic Oncology Program
PATIENT REFERRAL FORM**

FAX#: (603) 650-9496

Patient Information:

Name:	(H)	Address:
DHMC MRN #:	(W)	
Date of Birth:	(C)	
Current smoker? <input type="radio"/> No <input type="radio"/> Yes: Pack(s)/day _____ # of Yrs _____		

Referring Provider Information:

Provider Name:	Contact Person:
Staff Physician if different than above:	:

Information Required:		Send To:	
<i>In order to coordinate appropriate treatment options and care at the time of your patient's visit, the following items must be received:</i>			
All office notes, treatment notes, and lab reports		Fax To →	CTOP Fax # 603-650-9496
All pertinent Films/Images <i>FedEx/UPS/Courier ONLY Do NOT send Regular Mail</i>	Date sent to DHMC: _____ From (hospital): _____ Shipping Company: _____ Tracking No: _____	Send To →	DHMC Film Library One Medical Center Dr. Lebanon, NH 03756
Pathology slides	Date sent to DHMC: _____ From (hospital): _____ Shipping Company: _____ Tracking No: _____	Send To →	DHMC Pathology Attn: Candice Black, MD One Medical Center Dr. Lebanon, NH 03756

Management of Care:

- Evaluate and treat at DHMC
- We/the patient would like a 2nd opinion only.
- Please assume a subset of care:
Specify: _____
- Prefer Consultation with: _____

Service Requested:

- Smoking Cessation Program
- Second Opinion on films/scans
- Bronchoscopy/Biopsy – **must have films sent to DHMC first**

Previous Cancer Treatment:

Presenting Symptoms/Diagnosis:

Tests completed: Has patient had PFTs done in the past 90 days? Yes No

May we contact the patient to schedule?

- Yes - What was the patient told regarding the referral? _____
- No