**NIH Cancer Hospital Physician Referral Form**

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| **Patient Information** | | |
| Patient Name  Betty | | Patient Barcode Sticker |
| DOB, Medical Record Number (MRN)  ….…e5/744/6/1976……… …………………… …….. | |
| **Requesting Provider** | | |
| Assigned Provider/Practice Name:  Jane Ferreiro, MD / MyClinicalService | | Specialty/Department: |
| Address:  900 23rd St NW  Washington, DC 20037 | | Phone: (202) 555-1212  Facsimile #: (202) 555-1212 |
| **Consultant Provider** | | |
| Provider’s Name:  to be assigned | | Specialty/Department:  Molecular Science/M1 Training |
| Address:  2300 I St NW, Suite 201  Washington, DC 20052 | | Phone: (202) 555-1212  Facsimile #: (202) 555-1212 |
| **Referral Information** | | |
| Authorization No: | Authorization Type: | |
| Reason for Referral:  **TNBC Evaluation** | | |
| Diagnosis: **D68.311 – TNBC** | | |
| Clinical Notes: Betty is a 48-year-old African American (AA) woman with no significant comorbidities, otherwise healthy. Her mother was a breast cancer patient. She is a non-smoker, exercises regularly and moderately use alcohol. She complains of fatigue, localized pain in the breast and mild weight loss. Oncologists ordered an initial biopsy to assess the tumor. The result diagnosed Betty with high grade Triple Negative breast cancer, Stage III, 6 cm with lymph node involvement.  Oncologist advised Cisplatin-6 administer 75 mg/m2  Please consult with the family and send a copy of the final report back to this office. Thanks. | | |
| Procedures: Variant Interpretation – Molecular Impact Characterization | | |
| Visits Allowed: 3 | | |
| Unit Type: V (VISIT) | | |
| Referral is Valid Until: 09/30/2024 | | |
| Notes: Patient must arrive 30 minutes early, with a picture ID, Insurance card and have a copy of this referral. If the referred patient is a minor and anyone other than the child’s parents are escorting the child to the appointment, a letter of consent by the parent is needed. Please bring a list of medications the patient is taking with you to this appointment (including over the counter). | | |
| **Please send the final report by Fax to: (202) 555-1212** | | |
| Signature:    Ferreiro, Jane, MD on 08/29/2018 at 2:41 PM EDT | | |