ONCOLOGY Referral Form



of pages faxed _____

Centralized Referral Line:

866-408-1263

Centralized Referral Fax:

949-777-6750

OUR LOCATIONS

City of Hope National Medical Center Hospital-Based Outpatient Facilities

City of Hope Orange County Lennar Foundation Cancer Center

City of Hope Seacliff

Regional Network Clinics

Long Beach Elm

Long Beach Worsham

Newport Beach

Sand Canyon

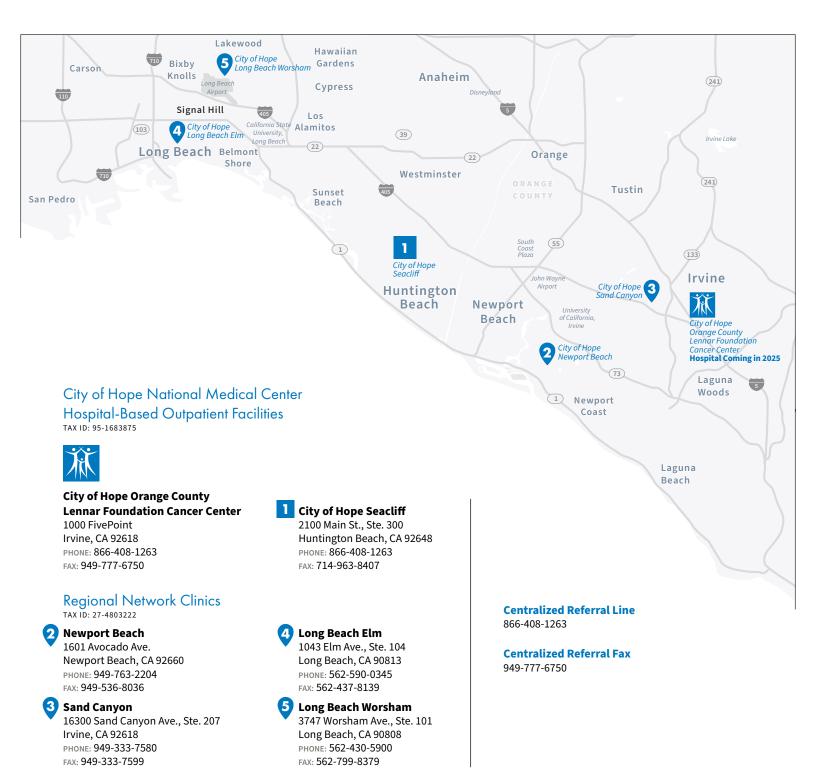
*Documentation Required (please fax with this form)

- ✓ Recent or relevant typed clinical notes/labs/test-pathology results/radiation reports/patient history/ related consultations and procedure reports/MRI/CT/X-ray results/other referral information
- ✓ Authorization information
- ✓ Insurance information

Referring Provider Information:

*Please provide all fields marked with a red asterisk

Referred by	
Medical Group	
*Phone *Fax	
Address	
City Zip	
This form completed by	
Patient Information (Please provide copy of patient demographics/face sheet):	
*Last Name	
*First Name	МІ
*Date of Birth/ *Gender: Male/Female *Phone	
Patient's Address	
Patient's Email	
*Primary Insurance	
Needs Interpreter? Y / N Language	
Reason For Referral:	
*Diagnosis/ICD-10	
*Service/Specialty Requested	
*Reason for Referral	
City of Hope Physician Requested (optional)	



CityofHope.org/OC/referrals









