MARY CROWLEY CANCER RESEARCH
HOPE LIVES HERE™

Referring and Primary Care Physician Information Sheet

Patient Name		Date of Birth	_______ /_______ /_______ mm dd yyyy
Appointment Date			
Purpose of this form	To ensure appropriate continuity of care, we will provide your Referring and Primary Physician(s) a copy of the progress notes throughout the duration of your participation on the clinical trial at Mary Crowley. We will also request your records from the physicians you note below.		
Instructions	1. Please list the name(s), specialty, phone and fax number of each of your physicians. Only the persons you list will be receive a copy of the progress notes. 2. Please list “None” if you do not have a Referring or Primary Physician. If you list none, a Primary Physician referral can be provided. Please discuss this option with one of our team members. Mary Crowley does not provide long term care once you have completed your participation on the clinical trial. 3. Please sign the bottom of this sheet to acknowledge that the information provided is complete and accurate.		

Referring Provider and Primary Oncologist Information

Physician’s Name	Type	Specialty	Phone Number	Fax Number
	☐ Referring ☐ Primary			
	☐ Referring ☐ Primary			

☐ I authorize Mary Crowley to keep the physicians noted above informed about my participation on the clinical trial.

☐ I do not authorize Mary Crowley to keep the following physicians informed about my participation on the clinical trial.

Please tell us how you heard about us (check one):

☐ Television	☐ Newspaper	☐ Friend or relative	☐ Radio	☐ Internet	☐ Primary Oncologist
☐ Physician:	Phone # _______ Fax # _______		☐ Other: Please list: _______		

_____________________________ Patient Signature

____________________ Date (mm/dd/yyyy)

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