EL PORTAL
COMPREHENSIVE CANCER CENTERS

Outpatient Referral Form

3303 M ST MERCED, CA 95348 | P: 209-726-3410 | F: 209-726-337

CLIENT INFORMATION: (please fill out on behalf of the client)

Patient Full Name:____DOB:__________________________

Address:____Phone:__________________________

Primary Insurance Name:_________________________________ID:____________________________

Secondary Insurance Name:_______________________________ID:____________________________

Is Auth Required? Auth #____

REFERRING PHYSICIAN INFORMATION:

Referring Physician:____

Diagnosis:____

Contact for Patient Follow-up:________________________________Phone:__________________________

PERTINENT MEDICAL HISTORY: Please provide chart notes that include demographics, diagnosis, past imaging/labs, current medications, and history of allergies or drug sensitivities.

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SPECIAL INSTRUCTIONS: ☐Routine ☐STAT

PLEASE INCLUDE:

- Demographics
- Diagnostic Exams (Imaging)
- Pathology/Labs
- Insurance/ID Cards
- Insurance Authorization
- Office Notes

PLEASE CONTACT OUR PATIENT CARE COORDINATOR TO SCHEDULE AN APPOINTMENT

PHONE: (209)205-2984 FAX: (209)726-3371

OFFICE LOCATIONS:

MERCED - 3303 M ST, MERCED, CA 95348 P: (209)726-3410

MADERA – 360 E. ALMOND AVE, 103, MADERA, CA 93637 P: (559)673-4600