UC DAVIS HEALTH | COMPREHENSIVE CANCER CENTER

New Patient Referrals
2279 45th Street
Sacramento, CA 95817

☐ Urgent ☐ Routine

Referral Form

Thank you for choosing UC Davis for your patient's medical needs. To initiate the referral process, please **FAX** this form to the UC Davis Comprehensive Cancer Center at **(916) 703-5266.**

- Include pertinent medical records, including test results/ pathology that supports the consultation only.
- Upon review and approval, we will then schedule an appointment with the patient.
- If you require additional assistance, please call **(916) 734-5959 opt 1** to speak to a Referral Coordinator.
- **Please note any missing or incomplete referral will be returned to the referring office to be completed.**

Please Print Clearly

Date:	From:
No. of pages:	Title:
To UC Davis Practice:	Phone: Fax:

Patient Information

Name of patient:		SSN/UC Davis MRN (optional):
Date of birth:	Sex:	Interpreter needed: ☐ Yes ☐ No Language:
Home phone number (with area code):		Work/cell phone:
If child, name of parent:		
Address:		
City:		Zip:

Patient Insurance

Insurance: Include patient's insurance card (both sides) and HMO authorization if required CPT Code 99245 x1, 99215 x3, 88321 x1, and 99205 x1

Insurance name/type:	ID number:	Group number:	Authorization number/Status:	Subscriber:

Consultation Request Information

Diagnosis/ICD 10:	
Name of UCD MD (if known):	Specialty:
Reason for consultation:	

Referring Physician Information

Referring MD:	Specialty:
Phone:	Fax:
PCP name:	Phone:

Internal Use Only

Delivered by: Date:	Triaged By: Date:
Approved Service:	Provider Specified: