Legacy Oral, Head and Neck Cancer Program

Physician Referral Form

LEGACY HEALTH

Complete form and fax to:
Phone: 503-674-1862
Fax: 503-674-1569
Hours: M–F, 8 a.m.–5 p.m.

Legacy Good Samaritan Medical Center
Allen Cheng, M.D., DDS, medical director,
Legacy Oral, Head and Neck Cancer Program

Patient information

Patient name _____

Patient-preferred phone _____

Patient date of birth *(mm/dd/yyyy)* _____

Does patient's insurance require referral?
○ No ○ Yes
☐ If yes, authorization #: _____ In process? ○ No ○ Yes

Does patient require interpreter?
○ No ○ Yes
☐ If yes, type: _____

Patient email: _____

Reason for referral

ICD-9/10 Code(s):

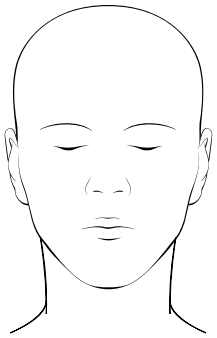
Instructions:
☐ Call patient to schedule
☐ Other:

Referral form completed by: _____

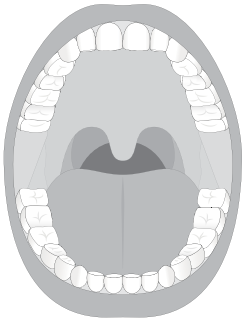
Requested surgical evaluation

(select or circle all that apply or main lesion site)

1. Front of head and neck



2. Inside of mouth



Additional patient records

Are there imaging studies?
○ No ○ Yes
If yes, where were they taken?

Are there pathology reports?
○ No ○ Yes
If yes, where were they taken?

Please forward most recent chart notes, imaging and pathology reports, demographic and insurance card.

Referring physician _____ Phone _____ Fax _____

Physician signature _____ Date _____