BLUE RIDGE CANCER CARE

Please allow 1-2 business days for appointment confirmations. For emergency appointments, please contact us at 1-855-833-BRCC (2722).

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FAX TO: 1-855-773-2722

MEDICAL ONCOLOGY NEW PATIENT APPOINTMENT REQUEST

Please help us help you *and your patient*. Complete all sections, providing as much information as possible.

APPOINTMENT SCHEDULING PREFERENCES

You Tell Us How You Would Like Us To Proceed! *(SELECT ONE)*

(NOTE: In either case, please initiate the referral process by selecting preference, providing details below and faxing this form. Or call our Schedulers.)

❑ 1.) BRCC schedulers call patient to schedule appointment date/time*

Please provide best phone # to call patient between 8AM & 5PM *(Circle one: Work, Home, Mobile)*_____

Preferred Physician:_____

[**BRCC TO COMPLETE** | Appointment Date/Time:_____]

* BRCC will contact your office or fax this form to Sender listed below to provide appointment details *(line above)*.

❑ 2.) BRCC schedulers call referring office to schedule patient** *(If selected, please call patient to provide appt. details.)*

Who at your office should we contact?_____ Phone #:_____

Patient prefers to be seen by:_____ OR First Available Appointment? ❑ *(check if preferred)*

Preferred appointment day/time? (Ex: Tues AM, Thurs PM, Any PM)_____

Preferred location: (circle one)

ALLEGHANY | BEDFORD | CHRISTIANSBURG | MARION | ROANOKE | ROCKY MOUNT | SALEM | WYTHEVILLE

***Every effort will be made to accommodate appointment requests.*

Using a printed demographic sheet? Please provide information from all sections below. To ensure scheduling accuracy, please clearly mark current diagnosis and primary insurance information. *Make this your cover sheet! Indicate total number of pages above.*

PATIENT'S INFORMATION

Name:_____ Date:_____

SSN:_____ Gender:_____ DOB:_____

Home #:_____ Work #:_____ Mobile #:_____

Address:_____

(Street Name, Apt. #) (City) (State) (Zip)

PATIENT'S INSURANCE INFORMATION

Primary Insurance:_____ Policy #:_____

Subscriber Name:_____ Subscriber DOB:_____

Subscriber SSN:_____

Secondary Insurance:_____ Policy #:_____

Subscriber Name:_____ Subscriber DOB:_____

Subscriber SSN:_____

REFERRING PHYSICIAN'S INFORMATION

Name:_____ NPI #:_____

Diagnosis (i.e., cancer type, heme, other):_____

SENDER'S INFORMATION *(Please let us know who is sending the fax, so we can provide appropriate updates.)*

Name: _____ Phone:_____ Fax:_____

Problems with scheduling or faxing? Please call our **New** Patient Schedulers: **1-855-833-BRCC (2722).**