SUMMIT
CANCER CARE
Medical Oncology & Hematology

CONFIDENTIAL FAX

ATTENTION: SUMMIT CANCER CARE NEW PATIENT REFERRALS

Fax to **912-800-6560**

OR

Email scanned documents to **drsoffice@summitcancercare.com**

OFFICE LOCATIONS

Savannah, GA | Springfield, GA | Statesboro, GA | Pembroke, GA

SUMMIT CANCER CARE PHYSICIANS

Ronald F. Goldberg, MD | Grant C. Lewis, MD | Barry D. Luskey, MD | Stephen A. White, MD

L.E. Bud Robertson, MD, FACP | Alison E. Spellman, MD | Mark A. Taylor, MD

NOTE: Patients will be scheduled with the physician who has the first available appointment at the location nearest the patient's home address unless specifically requested otherwise.

STAT? _____ yes _____ no

PLEASE ENSURE ALL BLANKS ARE COMPLETED

Patient Name _____ DOB ____/____/____

Patient Social Security Number _____–_____–_____ Patient Phone# _____

Diagnosis/Reason for Referral _____

Referring Physician Name _____

Referring Physician Phone# _____ Fax# _____

Referring Physician Contact Person _____

IMPORTANT! CHECK EACH ITEM BELOW and INCLUDE with your fax or email

☐ Copy of patient's insurance card ☐ Referral or authorization (if necessary)

INCLUDE THE FOLLOWING PERTINENT DOCUMENTS

☐ medical records ☐ pathology ☐ lab results ☐ diagnostic imaging ☐ other reports as applicable

FOR SUMMIT CANCER CARE USE ONLY Assigned to: _____

Date Form Received: ____/____/____ (circle any missing items above)

Appointment Date: ____/____/____ Time: _____ Staff Initials: _____