**Saint Luke's Hospital**
**Kansas City, MO 64111**

# Thoracic Center Referral

**Please fill out all information and fax to: 816-960-4498**

**Name:** _____ **Date:**_____
**DOB:**_____ **Sex :** **M F** **Age:**_____
**Address:**_____
**City:**_____ **State**_____ **Zip Code:**_____
**Home #:**_____ **Cell #:**_____
**Insurance:**_____ **Policy #**_____
**Insurance:**_____ **Policy #**_____
*** Please fax patient demographics, copy of insurance cards and any referrals**

**Referring MD:**_____ **Phone #:**_____
**Primary Care Physician:**_____ **Refer to (please circle) : Pulmonary**
**CT Surgeon**
**Follow-up Appt:**_____ **Med Oncology**
**Rad Oncology**
**Diagnosis:**_____

**Location of previous scans:**_____
**Previous biopsies?**_____

***Please send any medical records/films/ demographic sheets to our office via Fax 816-960-4498**
**Any questions, please call 816.932.3500**

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**Clinic Use Only:**

**Testing:**
**PFT:** _____
**CT:** _____ _____
**PET:** _____
**OTHER:**_____

**Date of Visit:**
**CTS:** _____
**PULM:**_____
**ONC:**_____

**Records Received:** _____/_____
**Patient Contacted:** _____/_____
**Mailed Paperwork:**_____/_____
**Plan Called to Pt:** _____/_____
**Date of Initiation of Tx Plan:**_____/_____
**Notes:**_____
_____
_____
_____
_____