BARBARA ANN KARMANOS CANCER CENTER
At the Detroit Medical Center

Radiology Appointment Request

Fax completed form to 313-576-8240 or call 800-527-6266
to request an appointment for your patient

Today's Date**:** _____

PLEASE ATTACH PATIENT RX/REFERRAL WITH APPOINTMENT REQUEST

Referring Physician Information

Name:_____

Address:_____City:_____State:_____Zip:_____

Office Contact Phone #:_____Fax #: _____

Contact Patient Directly: Yes: _____ No: _____

Patient Information

Demographic sheet attached**:** Yes _____ No _____ (if no, please complete entire form)

Name:_____

Address:_____City:_____State:_____Zip:_____

Date of Birth: _____

Insurance: _____ Policy #: _____ Group #: _____ Customer Svc. #: _____

BCCCP Enrollment Date: _____

Preferred Patient Phone #: _____ Alternate Phone #: _____ Best time to Call: _____ AM PM

Contact Person if not patient: _____ Relationship: _____ Phone #: _____

Referral Information: Location – Detroit: _____ Farmington Hills: _____

□ PET/CT (only available at Farmington Hills) □ CAT Scan □ MRI (Only available at Detroit Campus) □ Ultrasound

□ Annual Mammogram □ Diagnostic Bilateral Mammogram □ Diagnostic Left Breast □ Diagnostic Right Breast

□ General X-ray

Appointment Time - Morning: _____ Afternoon: _____ 1st Available: _____

Reason for Diagnostic Exam? _____

Date & Location of previous mammogram: _____

History of breast cancer? Yes: _____ No: _____ Does patient have breast implants? Yes: _____ No: _____

Does patient have special needs (use walker, cane or wheelchair)? Yes: _____ No: _____

Interpreter needed? Yes_____ No: _____ Please specify language: _____

Comments:_____