Professional Referral

Cancer Treatment Centers of America®
at Southeastern Regional Medical Center
Winning the fight against cancer, every day.®

Instructions:

Please fax completed form to **770-400-6900**. *If you should have any questions, or would like to discuss this referral, please call* ***770-400-6203***.

Patient Name _____

DOB _____ Phone Number _____

Primary Cancer _____

Date Diagnosed _____

Metastatic Site(s) _____

Date Diagnosed _____

Other Comments/Concerns

_____

_____

_____

Next Step:

In response to this referral, would you prefer us to contact the patient directly or call you first?

☐ **Call Patient Directly** ☐ **Call Me First**

Referring Professional _____

Specialty _____

Phone _____

Fax _____

Address _____

_____

Though Cancer Treatment Centers of America®(CTCA) would like to accept all patients, there are safety concerns and qualifying criteria a potential patient must meet prior to acceptance at CTCA®. This form serves as a suggested referral only. Please note that CTCA is under no obligation to accept or treat this patient. Referring Professional certifies to the best of his/her knowledge that the information on this form is accurate.

Professional Signature _____

Please fax completed form to **770-400-6900.**