



NEW PATIENT REFERRAL FORM

Call or Fax Your Referral

Phone: (816) 974-5050 • Referral Fax: (816) 683-7645

MEDICAL ONCOLOGY

HEMATOLOGY

Jaswinder Singh, MD

Nicholas Shuler, DO

Shajadi Patan, MD

Benjamin Fangman, MD

Chandandeep Singh, MD

Syed Karim, MD

LOCATION:

RESEARCH | 2316 E. Meyer Blvd., 1 East, Kansas City, MO 64132

BELTON | 17053 S. Outer Road, 1st Floor, Belton, MO 64012

PROVIDENCE | 8919 Parallel Pkwy., Suite 326W, Kansas City, KS 66112

REASON FOR CONSULT/DX CODE (REQUIRED) _____

Urgency: ASAP (24 hrs.) Routine (48-72 hrs.) 1-2 Weeks

Patient Name _____

Patient Address _____

Date of Birth _____ Phone _____

Cell _____ Referring Doctor _____

Phone _____ Fax _____

Primary Care Provider (*if different than the referring doctor*) _____

Phone _____ Fax _____

Primary Insurance Carrier _____

Name of Primary Policy Holder _____

Policy #/Group ID _____

Thank you for entrusting your patients' care to MidAmerica Cancer Care.

*We appreciate your confidence in MACC to care for your patients. Thank you for taking the time to send all required paperwork at time of referral (**recent office notes, lab, radiology reports and ALL pathology**) so we may see your patient as soon as possible. Please contact the office if you have any questions regarding necessary paperwork. **Thank you.***