SWEDISH
CANCER INSTITUTE
Extraordinary care. Extraordinary caring.℠

SWEDISH CANCER INSTITUTE

Center for Blood Disorders and Stem Cell Transplantation

1221 Madison St., 10th Floor, Seattle, WA 98104

Along with this referral form, please fax records to **206-670-9356**, including:

- Recent chart notes
- Recent 3-4 lab results
- Pathology, if applicable
- Imaging, if applicable

PATIENT INFORMATION (Please print)

Patient name:		DOB:
Patient address:	City, State, ZIP:	
Home phone:	Work phone:	Cell phone:
Primary insurance:	Subscriber ID:	Authorization number:
LMP_____ EDD_____ Not pregnant ☐	Interpreter required? ☐ YES ☐ NO Language: _____	

REFERRING PROVIDER INFORMATION

Referring provider name: _____ Phone: _____

Practice name: _____ Fax: _____

Address: _____

City/State/ZIP: _____

REFERRAL TYPE

☐ Benign hematology – Evaluate and treat	☐ Hematologic malignancy – Evaulate and treat
☐ Benign hematology – Consultation/2nd opinion	☐ Hematologic malignancy – 2nd opinion
☐ Benign hematology – Pre-surgical anti-coag planning	☐ Hematologic malignancy – Consultation for stem cell transplant
	☐ Hematologic malignancy – Clinical trials

ICD-10 CODE(S):

INDICATION:

Authorizing provider signature: _____ Date: _____