200 N. Park Street
Kalamazoo, MI 49007
Phone 269-382-2500
Fax 269-373-7431
www.wmcc.org

WMCC
West Michigan Cancer Center
Radiation & Surgical Specialties

Date_____

NEW PATIENT/ SELF - REFERRAL FORM

FAX COMPLETED FORM TO 269-373-7431 or **Mail to:**

West Michigan Cancer Center
Attn: Medical Records
200 North Park Street
Kalamazoo, MI 49007

Requested Service	Type of Referral	Appointment Requested	Physician Request
☐ Gynecologic Oncology ☐ Advanced Gynecologic Oncology ☐ Radiation Oncology ☐ Surgical Oncology	☐ Self-Referral	☐ First Available ☐ Urgent	☐ Any ☐ Dr. _____

Diagnosis/Reason for Referral:_____

Has the patient received treatment for this diagnosis at another facility: ☐ YES ☐ NO
If yes, please provide info below:

Physician Name: Phone Number: Fax Number: Dates of Treatment:

_____

_____

_____

PATIENT INFORMATION

A COPY OF THE FRONT AND BACK OF THE INSURANCE CARD ALONG WITH IDENTIFICATION ARE NEEDED TO SCHEDULE THE PATIENT

Patient Name: _____ Date Of Birth: _____

Address: _____City/State/Zip: _____

Primary Phone Number: _____ Email: _____

Sex (Legal) ☐ Male ☐ Female ☐ Nonbinary ☐ Unknown

Interpreter Services Needed: ☐ YES ☐ NO If yes, language: _____

Active Durable Power of Attorney or Legal Guardian: ☐ YES ☐ NO
If Yes, Name and Phone Number Below (please also include a copy)

Name: _____ Phone: _____