UCLA Health

MRN:
Patient Name:

(Patient Label)

PHYSICIAN CONTACT INFORMATION
DEPARTMENT OF RADIATION ONCOLOGY

Before your navigator call, please fax to (310)794-9795 OR return within 24 hours.

Please list names and phone numbers for all physicians caring for you.
Communicating with each of your physicians is an important part of our care plan.

Referring Physician ☐None ☐Decline to share
Physician:_____
Phone # _____
Fax # _____
Address: _____
_____
☐Office Use: Submitted to CC

Primary Care Physician ☐None ☐Decline to share
Physician: _____
Phone # _____
Fax # _____
Address: _____
_____
☐Office Use: Submitted to CC

Medical Oncologist ☐None ☐Decline to share
Physician:_____
Phone # _____
Fax # _____
Address: _____
_____
☐Office Use: Submitted to CC

Surgeon ☐None ☐Decline to share
Physician: _____
Phone #_____
Fax #_____
Address: _____
_____
☐Office Use: Submitted to CC

Cardiologist ☐None ☐Decline to share
Physician: _____
Phone #_____
Fax #_____
Address: _____
_____
☐ Office Use: Submitted to CC

Urologist/GYN ☐None ☐Declined to share
Physician:_____
Phone #_____
Fax #_____
Address:_____
_____
☐Office Use: Submitted to CC

Other Specialist ☐ Radiation Oncologist ☐ Dermatologist ☐ Ear Nose Throat (ENT) ☐Pulmonologist ☐Other _____
Physician: _____
Phone# _____
Fax# _____
Address: _____
_____
☐Office Use/Submitted to CC

Have you ever received radiation therapy?
☐ Yes ☐ No

Have you ever received chemotherapy?
☐ Yes ☐ No