SERVICE REQUEST FORM

*****If the patient is a US Citizen or Green Card Holder, please call our Physician Referral Service at 800-525-2225.*****

All medical records must be in English. Non English reports will be returned to the sender. Please do not send pathology slides, scans, images, or x-rays.

Please fill in the following information:

Citizenship _____

Patient Name _____ _____ ___ ___/___/___
Last First Sex Date of Birth

Home Address _____

City _____ **State** _____ **Postal Code** _____ **Country**_____

Phone _____ **Fax** _____
Country Code / Area Code / Number Country Code / Area Code / Number

Cell Phone _____ **E-mail** _____@_____
Country Code / Area Code / Number

Name of an individual we may contact on the patient's behalf:

Contact Name: _____

Relationship to patient: _____

Phone: _____ **Fax:** _____

E-mail _____@_____

Please check ☑ the best way to communicate with you: ☐ Phone ☐ Fax ☐ E-mail

*If you need a translator to communicate with us on the telephone, please indicate the language:_____

What is your current diagnosis? _____

Please check ☑ which service you are interested in:

☐ Medical record mail review ☐ On-site consultation ☐ On-site consultation and treatment ☐ Integrative Oncology Review

If you are interested in a clinical trial study, please provide trial name: _____

The following documentation is required for an MSKCC medical record review or request for an on-site consultation. Please send the most recent information. **ALL** submitted medical information **MUST** be translated into **ENGLISH.**

☐ Copy of the patient's passport
☐ Physician Medical Summary form detailing your condition and treatment
☐ Laboratory reports
☐ Surgical reports
☐ Pathology reports
☐ Radiology reports
☐ Chemotherapy administration records
☐ Radiation therapy records

****We will not proceed with your case if these requirements are not met****

Please check ☑ how you would like to receive a copy of the MSKCC medical record mail review report by the physician.

☐ E-mail ☐ Fax ☐ Postal Mail