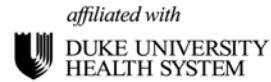




Beaufort Memorial KEYSERLING CANCER CENTER



THIS REQUEST FOR SERVICE MUST ACCOMPANY THE PATIENT AT THE TIME OF SERVICE

PATIENT INFORMATION

Patient name (last, first, MI) : _____

Address: _____

DOB: _____ SSN: _____ Sex: M F

Referring physician signature: _____

GENERAL INSTRUCTIONS: All orders must include an ICD-9 code or diagnosis. Tests not covered by that code might be charged to the patient. Please fill in the appropriate code or diagnosis for each test.

PLEASE SPECIFY SERVICE REQUESTED:

Radiation Oncology consult : Scheduling (843) 522-7800 FAX: (843) 524 - 0378

SERVICE	WITH DIAGNOSIS	ICD-9
1. _____		ICD-9 _____
2. _____		ICD-9 _____
3. _____		ICD-9 _____
4. _____		ICD-9 _____
5. _____		ICD-9 _____

Remarks / special instructions: _____

Appointment scheduled for Radiation Oncology, Date: _____ Time to arrive: _____

Appointment scheduled with Dr: _____

DEAR PATIENT:

Please be prepared to give your current address, phone number, picture identification, employer and insurance information.

Upon your arrive to the Beaufort Memorial Keyserling Cancer Center, please report to the reception area, where we will check you in and process your paperwork. Please remember to bring in your insurance cards with you on the day you arrive and present them to the registration personnel. In most cases, we will gladly file your insurance for you, but you are responsible for any charges not covered by your insurance.