Please securely email or fax completed information to CancerCARE at:
cancermanagement@cancercareprogram.com or 503.640.6277

CANCERCARE REFERRAL				
MEMBER INFORMATION				
TPA/Health Plan:			**Group:**	
Member:	☐ M ☐ F		**Date of birth:**	**Address:**
Phone(s):			**Email:**	
Diagnosis:			**Stage:**	**Date of diagnosis:**
☐ **Insured** ☐ **Dependent**	**Insured's Name:**			**Insured ID:**

	PROVIDERS	
☐	**Primary Care Physician:**	**Address/Phone:**
	ONCOLOGIST:	**Address/Phone:**
	SURGEON:	**Address/Phone:**
	Radiation Oncologist:	**Address/Phone:**
	FACILITY:	**Address/Phone:**
☐	**TREATMENTS**	
	Recent Treatment Request(s):	
	Recent Treatment Approval(s):	
	Known Treatment History:	
☐	**CASE MANAGER**	
	Referred by (company):	**Date:**
	Referred by (contact):	**Phone:**
	Additional Information:	
☐	**OTHER NOTIFICATION/ADDITIONAL INFORMATION**	

Form completed by:	**Phone:**	**Date:**

Please include any medical records you have for this Member