Radiation Oncology
Moakley Building
830 Harrison Avenue
Boston, MA 02118

PATIENT CONSULT REQUEST

DATE OF CONSULT REQUEST: _____/____/____

PT NAME: **_____**

PT DOB: _____/_____/_____

PT BMC MRN:_____

PATIENT DIAGNOSIS:_____

REFERRING MD:_____PCP_____

OFFICE PHONE_____ FAX_____

CONTACT:_____

PATHOLOGY REPORT IN LOGICIAN: YES NO

HAS THIS PATIENT BEEN DISCUSSED WITH A RADIATION ONCOLOGIST?
YES NO
HAS PATIENT BEEN SEEN IN BMC RADIATION ONCOLOGY BEFORE?
YES NO

If yes, name of Radiation Oncologist M.D._____

Schedule Patient Appointment within (PLEASE CHECK ONE):

___EMERGENT ___1 WEEK ___2 WEEKS

PLEASE FAX REQUESTS TO: 617.638.7037
PLEASE SEND
Pathology report and slides
X-rays

PLEASE CALL 617.638.7070 WITH ANY QUESTIONS.

For office use only
Date received_____ Date of Appointment_____

Logged in by_____ Physician assigned _____

Date Referring MD or patient notified_____