PHYSICIAN REFERRAL FORM FOR PARTICIPATION IN CLINICAL TRIALS

UK MARKEY CANCER CENTER – PRECISION MEDICINE CENTER
1-859-323-7372
Please fax to: 859-257-0100
9Y`l·ìfŸ etccart@uky.edu
Please include MD summary or H&P and most recent labs and scans if patient is not currently being seen at UK

Name: DOB: Phone (H): Phone (M):

Address:

Allergies:

Performance Status: Peripheral Neuropathy: ☐ Yes ☐ No If yes, grade:

Cancer Type: Stage: Metastatic: ☐ Yes ☐ No

Second Primary: ☐ Yes ☐ No If yes, where:

Measurable Disease: ☐ Yes ☐ No If yes, where:

Date of last radiation (mm/dd/yy): Date of last surgery (mm/dd/yy):

Date of most recent progression (mm/dd/yy): Last date of most recent treatment (mm/dd/yy):

LIST PREVIOUS LINES OF THERAPY STARTING WITH MOST RECENT (DO NOT PROVIDE DATES)

_____
_____
_____
_____
_____

Known genomic alterations:_____
Targeted therapy received:_____

Brain Mets:	☐ Yes	☐ No	Treatment:_____
Current anticoagulant use:	☐ Yes	☐ No	Reason taking, dose/frequency:_____
History of clotting:	☐ Yes	☐ No	Comments:_____
Current Use of steroids:	☐ Yes	☐ No	Reason taking, dose/frequency:_____
Edema/ascites/effusions:	☐ Yes	☐ No	Location:_____
Biopsiable disease:	☐ Yes	☐ No	Location:_____
Diabetes:	☐ Yes	☐ No	Comments:_____

Referring MD_____ UK MD (if different from referring MD)_____

Phone_____ Fax

Date

Office Use Only

Insurance e-mail to financial evaluator date:_____
Response from evaluator: ☐ Yes ☐ No Date:_____
Comments:_____
_____
_____

Appointment Date:_____
MD:_____
Study Number:_____
Records:_____
E-mail sent:_____
RN:_____