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
Email: 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)

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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:______________________________
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Appointment Date:________________

MD:________________

Study Number:________________

Records:________________

E-mail sent:________________

RN:________________