METRO HEALTH
UNIVERSITY OF MICHIGAN HEALTH

Cancer Care

Requesting Consultation Form

Date: ______________________

Patient Name:____ DOB: ________________

PLEASE FAX ALL PERTINENT RECORDS (DEMOGRAPHIC PAGE, OFFICE NOTES, PATHOLOGY REPORTS, OPERATIVE NOTES, LAB RESULTS, RADIOLOGY REPORTS) TO 616.252.8181.

Requesting Office Information:

Name of requesting provider: ____

Phone Number: (______) ________________ Fax Number: (______) ________________

Contact Person: ______________________ Direct Number (if applicable): (______) ________________

We are requesting a consult with:

☐ Dr. Stephanie Dublis ☐ Dr. Michael Zakem ☐ Dr. Sulsal Haque

Diagnosis: ____

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Please indicate one of the following:

☐ Patient **is aware** of the referral. Please contact the patient directly to schedule and fax the referring office the appointment date/time.

☐ Please call the referring office above to schedule appointment.

☐ Please fax the referring office above the appointment date/time and the referring office will notify the patient.

Please order prior to appointment: ____

Appointment is scheduled for:______________________ with______________________
(Date/Time) (Provider)

**** Iron Deficiency Anemia for pre-menopausal women must meet one of the following criteria:**

- Status post gastric bypass surgery
- Failure of adequate trial of oral iron (Less than 1-2gm increase in HGB over 4-6 weeks on 325mg FeSO4=TID)
- Definite intolerance to oral iron
- Negative GI work up if non menstruating

If the patient does not meet one of the criteria above, please feel free to call the office and speak directly to one of the doctors to discuss the care of your patient.

****Hematology referrals can take up to 3 business days as the physicians will review the records prior to scheduling. There may be labs requested to be done prior to appointment.**

METRO HEALTH CANCER CENTER

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10/20