WOMEN'S CANCER AND SURGICAL CARE, P.C.

4610 Jefferson Lane NE
Albuquerque, NM 87109
Tel: (505) 559 – 4495 Fax: (505) 842 – 8025

PRIORITY FOR SCHEDULING PATIENT ☐ **1-2 days** ☐ **3-5 days** ☐ **6-10 days**

PATIENT NAME: _____

DATE OF BIRTH: _____ **PATIENT PHONE (Home):**_____

PATIENT PHONE (Cell):_____ **(Work):**_____

INSURANCE: _____ **Authorization Number (If needed):**_____

DIAGNOSIS: _____

REFERRING DOCTOR: _____

☐ **OVARIAN CARCINOMA**	☐ **VIN I – II**
☐ **ENDOMETRIAL CARCINOMA**	☐ **VIN III**
☐ **CERVICAL CARCINOMA**	☐ **VULVAR CARCINOMA**
☐ **PELVIC MASS**	☐ **ELEVATED CA-125**
☐ **BORDERLINE OVARIAN TUMOR**	☐ **UTERINE SARCOMA**
☐ **FAMILY HISTORY OF OVARIAN CANCER**	☐ **FAMILY HISTORY OF BREAST CANCER**
☐ **PERSONAL HISTORY OF BREAST CANCER**	☐ **BRCA POSITIVE**
☐ **ELEVATED CEA**	☐ **OTHER**_____

_____

It is necessary to provide the following documentation that supports the request for an appointment:

a) **Progress notes/ most recent H&P**
b) **Current medication list**
c) **Lab results (CA-125 and / or other tumor markers)**
d) **Radiology reports (pelvic ultrasound and / or CT scan or MRI)**
e) **Operative notes with the corresponding pathology reports**

Thank you in advance for helping us to expedite the appointment process when seeing your patients in a timely fashion.