UNC HOSPITALS

NC Cancer Hospital
Bone Marrow and Cellular Therapy Program
101 Manning Drive, Chapel Hill, NC 27514
Phone: 984-215-5123 Fax: 984-974-8788
Email: unccart@unchealth.unc.edu

New Patient Referral/Consultation – CAR-T Therapy

Please fax completed referral form and all pertinent records to 984-974-8788. Questions? Call 984-215-5123.

Date of Request: ________________ Diagnosis: ____

PATIENT INFORMATION

Patient Last Name: __________________________ Patient First Name: _______________________ MI: _____

Date of Birth: ______________________ Sex: ☐Male ☐Female Race: _________________________

Address: ____

City: ______________________________ State: _________ Zip: _____________ Country: ____________

Home Phone: ______________________ Mobile: ____________________ Work: ______________________

Email: ____ SSN: _______-_______-___________

INSURANCE POLICY HOLDER INFORMATION

Please enclose copy of insurance card, front and back.
Patient must have active insurance coverage before a consult is scheduled.

Policy Holder's Relationship to Patient: ☐Self ☐Parent ☐Spouse ☐Child ☐ Other: ___________________

Last Name: ____________________________ First Name: _____________________________ MI: _______

Date of Birth: ____________________ Sex: ☐Male ☐Female Primary Phone #: _______________________

Primary Insurance: _______________________ Policy #: ______________________ Group # _____________

Secondary Insurance: _______________________ Policy #: ____________________ Group #: _____________

REFERRING PHYSICIAN INFORMATION

Physician Name: ____ Office Contact: _______________________

Physician Email: ____ Phone: _______________________

Fax: _______________________ Institution / Clinic Name: ____

How did you hear about UNC CAR-T Program?: ____

Has the patient been informed of referral to UNC? ☐Yes ☐No

Is the patient currently hospitalized? ☐Yes ☐No Anticipated discharge date? ________________________

How soon is appointment needed? ☐1 – 3 weeks ☐4 – 6 weeks ☐Other: ___________________________

Additional comments / requests: ____

We will contact the patient about their appointment date and time, unless otherwise requested. Thank you!

UNC ONLY: Date received: _______________________ MRN:____

Date & Time of Appointment: ____ MD: ___________________________________

Form: BMTCTP CAR-T Intake 05/21