RADIANT
CANCER CARE

Referral Form

Date: _____ **Referring Provider:** _____

Patient Information:

Name:_____ DOB_____

Phone Number:_____

Address: _____

Insurance Name: _____

ID number: _____

Clinical concern to be addressed: _____

_____

Please fax referral form & records to: 760-770-4392

Carolyn Barnes, MD

Board Certified Radiation Oncologist

Ted Ling, MD

Board Certified Radiation Oncologist

40055 Bob Hope Drive

Suite B

Rancho Mirage, CA 92270

Ph: 760-202-3946