

The Boston Gamma Knife Center at Tufts Medical Center  
Patient Referral Form



All patient information will be kept confidential.

\* Fields marked with a red asterisk are required.

Please fax this referral form to 617-636-7587.

Physician Name: \*

Specialty:

Phone #: \* (  )

Fax #: (  )

Patient Name: \*

Patient Home Phone: \* (  )

Patient Work/Cell Ph: (  )

Date of Birth: \*  -  -  (for example: 04-19-1967)

Patient Address: \*

Male  Female  \*

Clinical Information

Diagnosis: \*

If Mets, list primary:

Other physicians involved in patient's care:

Location of films:

Prior radiation (list location & date):

Prior surgery:

For additional comments, please write them on another piece of paper and fax together with this form.

