

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.

