BAMF Health Theranostics Center • Molecular Therapy Clinic
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Clinical Trial Referral Form
Revision 03/09/2025

If a provider referral, please send the following: ☐ All notes ☐ Pathology Report ☐ Labs ☐ Treatment Documentation ☐ Recent Radiology Reports/Images

To ensure timely processing, please complete all required fields marked with ***. If additional information is available, it is encouraged, but not mandatory

Patient Information

Patient Name: ***		☐ Male ☐ Female	DOB: ***	
Patient Phone #: ***		Patient Email Address:		
Patient Address:				
Patient City, State, Zip Code:				

Primary Insurance Provider:		Member ID:		Group#:	
Secondary Insurance Provider:		Member ID:		Group#:	

Clinical Information

Diagnosis: ***			
Clinical Trial of interest: ***		If ineligible for Trial, "second opinion consultation" desired?	☐ Yes ☐ No
Current plan of care:			

Please list Patient's current providers:	Specialty	Name of provider & facility	Contact information
	Primary care provider:		Phone: Fax:
	Medical Oncologist:		Phone: Fax:
	Surgical Oncologist		Phone: Fax:
	Radiation Oncologist		Phone: Fax:
	Applicable specialists:		Phone: Fax:

Referring Contact Information

Referring Contact Name: ***		Phone: ***	
Facility Name:		Fax: ***	
If referred by provider, list name & specialty:		Timeline to get patient into BAMF:	
How did you hear about us?			

Additional Notes for BAMF Health Team

Please provide any additional information below:

Note: Email form to researchclinicalteam@bamfhealth.com or Fax to (616) 253-8365 "ATTN: Clinical Trials"