UPDATED 05/2024

CLEARVIEW CANCER INSTITUTE

888-374-1015 | NEW PATIENT REFERRAL FAX: 833-705-4101

We will contact your office with appointment information. Please include a copy of the patient's demographics page with the referral form.

ANNISTON
901 Leighton AVE #602

- ○ Rami Atallah, MD
- ○ Robert M. Conry, MD
- ○ First Available
- ○ Genetic Counseling

ATHENS
707 West Market ST

- ○ Brian Mathews, MD
- ○ Heather Shah, MD
- ○ First Available
- ○ Genetic Counseling

CULLMAN
1948 AL HWY 157, POB 1 STE 380

- ○ Michael Garcia, MD
- ○ Amy Stubbs, MD
- ○ First Available
- ○ Genetic Counseling

DECATUR
1107 14th AVE SE, STE 200

- ○ Diego Bedoya, MD
- ○ Naveen Lobo, MD
- ○ Rishi Patel, MD

1310 14th AVE SE

- ○ Heather Shah, MD
- ○ First Available
- ○ Genetic Counseling

HUNTSVILLE (CRESTWOOD)
One Hospital DR, STE 400

- ○ Paul Dang, MD
- ○ Jorge Diaz, MD
- ○ Benjamin Miriovsky, MD
- ○ First Available
- ○ Genetic Counseling

HUNTSVILLE (RUSSEL HILL)
3601 CCI DR

- ○ Sri Bathini, MD
- ○ Diego Bedoya, MD
- ○ Paul Dang, MD
- ○ Jorge Diaz, MD
- ○ Ehab El-Bahesh, MD
- ○ Kanth Katragadda, MD
- ○ Brian Mathews, MD
- ○ Philip McGee, MD
- ○ Benjamin Miriovsky, MD
- ○ John R Nicholson, MD
- ○ Daniel Schreeder, MD
- ○ Marshall Schreeder, MD
- ○ Wes Smith, DO
- ○ John Waples, MD
- ○ First Available
- ○ Genetic Counseling

JASPER
3500 HWY 78 E, STE A

- ○ Michael Garcia, MD
- ○ Amy Stubbs, MD
- ○ First Available
- ○ Genetic Counseling

MADISON
12090 County Line RD, STE B

- ○ Ehab El-Bahesh, MD
- ○ Genetic Counseling

SCOTTSBORO
380 Woods Cove RD

- ○ Paul Dang, MD
- ○ John R. Nicholson, MD
- ○ Genetic Counseling

FLORENCE
180 Cox Creek PKWY

- ○ Brett Barlow, MD
- ○ Heather Brody, MD
- ○ Daniel Kingsley, MD
- ○ First Available
- ○ Genetic Counseling

FLORENCE
1751 Veterans DR

- ○ Patrick Daugherty, MD
- ○ Genetic Counseling

MUSCLE SHOALS
101 Blake DR

- ○ Brett Barlow, MD
- ○ Heather Brody, MD
- ○ Daniel Kingsley, MD
- ○ First Available
- ○ Genetic Counseling

Referral Date: ___/___/_____

Referring Physician's Full Name: _____

NPI#: _____ Office#: _____ Office Fax #: _____

Patient Full Name: (First) _____ (Middle) _____ (Last) _____

DOB: ___/___/_____ Age: _____ ○ MALE ○ FEMALE SSN: _____

Patient Address: _____

City/State: _____ Zip Code: _____

Is Language Assistance Required? ○ YES ○ NO Primary Language: _____

Primary Contact#: _____ Alternate Contact#: _____

Email: _____

Reason for Referral/Diagnosis: _____

Primary Insurance: _____ Contract#: _____ Group Number: _____

Secondary Insurance: _____ Contract#: _____ Group Number: _____

To be completed by CCI - APPT Date: ___/___/_____ APPT Time: _____ ○ AM ○ PM