**Clinical Trials Navigator Referral Form**

**DIAGNOSIS:**

**CURRENT TREATMENT AND LINE OF THERAPY (e.g. first line metastatic, on carboplatin):**

**CURRENT THERAPY COMPLETION DATE (Approximate)**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ or [ ]  N/A

 Month/Day/Year

**REPORT TURNAROUND REQUESTED: □ < 1 week □ < 3 weeks**

**CLINICAL TRIAL THERAPY REQUEST (select ALL applicable options):**

[ ]  Exploration/Next Generation Sequencing

[ ]  Immunotherapy

[ ]  Chemotherapy

[ ]  Radiation

[ ]  Other (E.g. Screening, QOL, etc.) Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CLINICAL TRIAL THERAPY INTENT: □ CURATIVE □ PALLIATIVE**

**To be filled out by Referring Physician**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact info: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**To be filled out by Clinical Trial Navigator**

Initial Consultation Date:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_