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| REFERRAL FORM |
| Fax: 910-641-8329 |



Please Circle One: URGENT ROUTINE

Date of Referral:\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Referral Type: Hematology Oncology

Reason for Referral (Diagnosis):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Gender: M F Patient Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referring Provider:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Office Contact Name:\_\_\_\_\_\_\_\_\_\_\_\_

Office Fax Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please provide the following supporting documentation:**

1. Facesheet 2. Copy of Insurance Card 3. Physician Notes 4. Lab Results 5. Pathology Reports (Oncology) 6. Imaging Reports (Oncology)

Comments/ Additional Information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\*\*\***URGENT REFERRALS:** Please follow up by phone to ensure the referral is addressed in a timely manner. If you have any questions, please contact our office for Hematology (910) 641-8220 and for Oncology (910) 640-4077.