SOUTHERN ONCOLOGY SPECIALISTS

REFERRAL FORM / CONSULT
MEDICAL ONCOLOGY-HEMATOLOGY

William R. Mitchell, MD – Jack D. Burton, MD – Poras K. Patel, MD
James H. Liang, MD – Jennifer L. Dallas, MD – Moses S. Raj, MD

Patient's Name_____ DOB_____
Home # _____ Cell # _____ Work #_____
Address_____ City/State/Zip_____
Patient Insurance_____
Does the patient's insurance require a referral authorization from the PCP? □YES □NO
If YES, Authorization #_____

Diagnosis/Reason for Referral_____
Special Notes_____
Referring Provider_____ Practice Name_____
Address_____
Contact at office_____ Phone#_____
Fax#_____

Referral Coordinator-Stacy Nelson direct # 980-213-2728

Please fax all pertinent progress notes, radiology reports, pathology reports, labs, demographics and copy of insurance cards (front & back) to fax 877-881-8455

OUR OFFICE WILL FAX BACK THIS FORM WITH SCHEDULED APPOINTMENT INFO		
Date of Appointment:	Time:	AM / PM
Our Office Location:	With Physician:	

HUNTERSVILLE:
9930 Kincey Ave,
Suite 165
Huntersville, NC 28078

DENVER:
268 Gillman Rd,
Suite A
Denver, NC 28037

MOORESVILLE:
146 Medical Park Rd,
Suite 212
Mooresville, NC 28117

CHARLOTTE:
10320 Mallard Creek Rd,
Suite 100
Charlotte, NC 28262

STATESVILLE:
1405 Fern Creek Dr
Statesville, NC 28625

HICKORY:
2660 Tate Blvd SE,
Suite 201
Hickory, NC 28602