



REFERRAL FORM / CONSULT
MEDICAL ONCOLOGY-HEMATOLOGY

Today's Date _____

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# _____

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

HUNTERSVILLE	CHARLOTTE/UNIVERSITY	DENVER	MOORESVILLE	STATESVILLE
9930 Kinsey Ave, Ste 165 Huntersville, NC 28078 704-947-5005	10320 Mallard Creek Rd, Ste 100 Charlotte, NC 28262 704-945-6843	268 Gillman Rd, Ste A Denver, NC 28037 704-659-7830	146 Medical Park Rd, Ste 212 Mooresville, NC 28117 704-659-7850	1405 Fern Creek Dr. Statesville, NC 28625 704-659-7866

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

Fax # 877-881-8455

Direct referral number 980-213-2728 **STACEY NELSON**

William R. Mitchell, MD – Jack D. Burton, MD – Poras K. Patel, MD

Ramesh K. Pandey, MD - James Liang, MD