REFERRAL FORM / CONSULT
MEDICAL ONCOLOGY-HEMATOLOGY

William R. Mitchell, MD - Jack D. Burton, MD - Poras K. Patel, MD
Ramesh K. Pandey – James Liang, MD

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#__________________________________

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	CHARLOTTE/UNIVERSITY	DENVER	MOORESVILLE	STATESVILLE
9930 Kincey 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