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 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	738 Bryant St Statesville, NC 28677 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

If you have any questions, please call us at 704-659-7850