



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

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