



REFERRAL FORM FOR HEMATOLOGY & ONCOLOGY SERVICES

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Direct Referral Address: admin@dho.oncoemrdirect.com

Thank you for your referral, **MEDICAL RECORDS ARE REQUIRED** with your referral form in order to thoroughly evaluate and make recommendations. All referrals **MUST HAVE RECENT LABS, OFFICE NOTES AND ALL PATHOLOGY REPORTS SENT BEFORE** the patient's appointment date. We apologize for any inconvenience to you and your staff, but it is essential we have the following information:

- Most recent History and Physical and the most recent Physician's Note.
- Most recent Laboratory testing and Tumor markers. (**last 3 months of labs if being seen for a hematology consultation**)
- Most recent Imaging Procedures and Testing, such as Ultrasound, Nuclear Scans, MRI CT, PET CT Scans, ETC.
- **ALL Pathology Reports. (ER/PR Her-2 neu if Breast CA) (EGFR/ALK if Lung Cancer)**
- **List of current medications**
- Demographics & Copy of Insurance cards
- **Insurance Authorization for the patient referral should be obtained prior to the scheduled appointment date.**

PLEASE PRINT CLEARLY & FILL OUT COMPLETELY

Patient Name: _____ DOB: _____

SS#: _____ Cell Phone: _____ Home Phone: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____

Primary Insurance & Policy Number: _____

Authorization/Referral # (if required): _____

Secondary Insurance & Policy Number: _____

Referring Physician: _____ Office Phone: _____ Office Fax: _____

Diagnosis for Referral: _____

Patients Primary Care Physician if other than referring: _____

Name of contact person: _____

APPT DAY/DATE: _____ APPT TIME: _____ with DR. _____

We will fax this form to your office with the appointment information.
We ask that you notify your patient of the date and time of the appointment.
Patient should arrive 20 minutes prior to scheduled appointment time
Bring a list of Medications & Photo ID/Insurance Cards

Initials _____

Date _____