DOTHAN Hematology + Oncology

101 Westside Drive
Dothan, Alabama 36303

Telephone: (334) 792-9500 Fax: (334) 625-6559

Direct Referral Address: admin@dho.oncoemrdirect.com

REFERRAL FORM FOR PSMA-PET

Thank you for your referral, **MEDICAL RECORDS ARE REQUIRED** with your referral form. 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 PSA
- Pathology Reports
- Demographics & Physical copy of Insurance cards

PLEASE PRINT CLEARLY & FILL OUT COMPLETELY

Patient Name: _____ **DOB:** _____

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

Mailing Address: _____

City: _____ **State:** _____ **Zip:** _____

Email Address: _____

Primary Insurance: _____

(Not accepting Primary Medicaid or Aetna)

Policy Number: _____

Authorization/Referral # (if required): _____

Secondary Insurance & Policy Number: _____

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

Reason for Referral: _____

Patient's 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 will 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 _____