Hematology Oncology Associates
New Consult Referral Form
Phone (315)472-7504 option 2
Fax (315)634-5170

Please check appropriate appointment request:
☐ **Medical Oncology** ☐ **Radiation Oncology** ☐ **Both Med Onc/Rad Onc**

Date of referral: _____ **Referring MD:** _____ **Phone:** _____

Patient Name: _____ **DOB:** _____

Patient Address: _____ **City:** _____ **Zip:** _____

Patient Phone: Preferred _____**home/cell** **Alternate** _____**home/cell**

SSN: _____

*****Please include a copy of insurance card*****
Insurance: _____ **ID**_____
Insurance: _____ **ID**_____

Reason for referral/Diagnosis: _____**Is patient aware of this referral? Yes/No**
☐ Opinion ☐ Assume/Manage care for diagnosis ☐ Co-Manage Care

Urgency: ☐ Routine cancer 7-10 days
☐ **Urgent less than 48 hours MD must call MD**

Please fax pertinent information related to this diagnosis or reason for referral:

LEUKEMIA - AML, ALL, CML, CLL:

CBC's with differential x 1 year	Enclosed___	
Recent labs (CP, LDH, Rectic, TIBC)	Enclosed___	Not performed___
CT scans (ALL, CLL)	Enclosed___	Not performed___
CXR	Enclosed___	Not performed___
MD Progress notes	Enclosed___	

The following may not be available unless previously seen by hematology oncology clinician:

Bone marrow reports	Enclosed___	Not performed___
Cytogenetic reports	Enclosed___	Not performed___
Lymphocyte phenotyping (CLL)	Enclosed___	Not performed___
Flow cytometry	Enclosed___	Not performed___
Genetic Testing	Enclosed___	Not performed___

In addition, we request the following information for all new referrals:
Relevant Medical History
Allergy List
Medication List
Language, cultural, ethnic and communication needs
Advanced directives