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

**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 within 4-6 weeks
☐**Urgent less than 48 hours MD must call MD**

**For the purpose of continuity of care, please fax pertinent information related to the reason for this referral:**

**<u>LYMPHADENOPATHY REFERRALS:</u>**

| | | |
|---|---|---|
| Labs | Enclosed_____ | |
| MD progress note | Enclosed_____ | |
| Referral note | Enclosed_____ | |
| Imaging | Enclosed_____ | |
| Pathology report from biopsy | Enclosed____ | Not performed_____ |
| Genetic testing | Enclosed____ | Not performed_____ |

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