East Syracuse * Onondaga Hill * Auburn
315-472-7504 Office Phone option 2
315-382-6479 Nurse Navigator Phone
315-634-5170 Fax

HOACNY/UPSTATE/CROUSE Thoracic Surgery Program: New Consult Referral Form

Date of referral: _____________ **Referring MD:** _____________________ **Phone:** _____________

Referral Coordinator Name: _____________________ **Phone:** _________________

Patient Demographics
[ ] Demographics attached (if YES, may skip Patient Demographics section)
Name: ____ **DOB:** ___________

Patient Address: __________________________________ **City:** _______________ **Zip:** __________

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

SSN: ____________________

Patient Insurance
[ ] Front and back of insurance card attached (if YES, may skip Patient Insurance section)
Primary Insurance: _________________________________ **ID**______________________
Subscriber Name: ______________________________ Group # ______________________
Secondary Insurance: _________________________________ **ID**______________________
Subscriber Name: ______________________________ Group # ______________________

[ ] Reason for referral/diagnosis: ____ **Is patient aware of referral? Y/N**

Urgency: **[ ]** Routine cancer within 7 – 10 business days
[ ] Urgent less than 48 hours MD must call MD

<u>We require the following information for all new referrals for continuity of care:</u>

- Pathology report from biopsy — Enclosed___ Not performed___
- Pathology report from resection — Enclosed___ Not performed___
- Cytology from bronchoscopy — Enclosed___ Not performed___
- Operative notes from above procedures — Enclosed___ N/A___
- Genetic Testing — Enclosed___ Not performed___
- EKG — Enclosed___ Not performed___
- Pulmonary function test report — Enclosed___ Not performed___
- CXR — Enclosed___ Not performed___
- CT scans(chest, abdomen) — Enclosed___ Not performed___
- Bone scan — Enclosed___ Not performed___
- Pet/CT — Enclosed___ Not performed___
- Most Recent MD Progress Note — Enclosed___
- Allergy List — Enclosed___
- Medication List — Enclosed___
- Medical/Surgical History — Enclosed___
- Family History — Enclosed___