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

****Specific MD requested**_____ ****Specific location requested**_____

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

HIGH RISK BREAST CANCER:

Upcoming surgery date?	Date_____		
Is post op scheduled?	Date_____		
Op note from surgery	Enclosed___	Not performed___	
Path from surgery	Enclosed___	Not performed___	
Op note from biopsy	Enclosed___	Not performed___	
Path from biopsy	Enclosed___	Not performed___	
Mammogram reports	Enclosed___	Not performed___	
Breast ultrasound reports	Enclosed___	Not performed___	
Breast MRI results	Enclosed___	Not performed___	
Genetic testing (BRCA I+II)	Enclosed___	Not performed___	Results pending___
MD Progress notes	Enclosed___	Not performed___	
Family History (may be on PN)	Enclosed___	Not performed___	

Prior treatment; (chemotherapy, radiation therapy, hormonal) Enclosed___ N/A___

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