

**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:**

**MISCELLANEOUS REFERRAL:**

History and Physical (most recent)	Enclosed	___
Family History	Enclosed	___
MD progress notes	Enclosed	___
Labs related for referral	Enclosed	___
Imaging reports related for referral	Enclosed	___
Biopsy reports related for referral	Enclosed	___
Specialist reports related for referral	Enclosed	___
Operative/Endoscopy if related for referral	Enclosed	___
Genetic Testing	Enclosed	___
	Not performed	___
	Not performed	___
	Not performed	___
	Not performed	___
	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