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:

Monoclonal Gammopathy/MGUS

CBC for Past Year	Enclosed___
Chemistry Profile & LDH for past year	Enclosed___
Immunoglobulin Levels from past year	Enclosed___
Imaging-X-Rays	Enclosed___
MD progress notes	Enclosed___
Genetic Testing	

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