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

Please check appropriate appointment request:
☐ **Medical Oncology** ☐ **Radiation Oncology** ☐ **Both Med Onc/Rad Onc**

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 cancer 7-10 business days
☐ **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:

TESTICULAR CANCER:

Pathology report from biopsy	Enclosed___	
Pathology report from surgery	Enclosed___	Not performed___
Genetic testing	Enclosed___	Not performed___
Operative note	Enclosed___	
Physician referral/Progress notes	Enclosed___	
CXR	Enclosed___	
CT scan	Enclosed___	
Recent lab (AFP, BhcG, LDH)	Enclosed___	Not performed___
Prior treatment (chemo, RT)	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