

# Referral Form

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## Patient Information

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Patient Name:

SSN:

Date of birth:

Gender:

Phone number:

Address:

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## Clinical Information | Patient History

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\*Referring physicians, please make sure referral is complete by faxing all records regarding the patient's diagnosis, including any past records obtained to help ensure a timely appointment

### Oncology

- Referral Reason and diagnosis
- Oncology consultation note(s)
- Imaging reports (CT, MRI, PET, mammogram, etc.)
- Pathology report(s)
- Surgical report(s)
- Lab results (CBC, CMP, tumor markers)
- Radiation oncology notes (if applicable)
- Chemotherapy records (if applicable)
- Genetic testing results (if available)
- Primary care or referring provider notes
- AUTH if needed (CPT Codes 99203, 99204, 99205 for Consult)

### Hematology:

- Referral Reason and suspected diagnosis
- Most recent CBC and CMP
- Iron Studies, B12, folate, reticulocyte count
- SPEP/UPEP, Immunoglobulin Levels (if applicable)
- Bone marrow biopsy results (if done)
- Imaging reports (e.g., if lymph nodes or spleen evaluated)
- Relevant Historical Labs (especially if chronic condition)
- Referring Provider's clinical note
- AUTH if needed (CPT Codes 99203, 99204, 99205 for Consult)

Prior Chemotherapy:

Prior XRT:

Provided by:

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PCP:

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Diagnosis/Symptoms:

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Notes:

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Referring Physician:

Date:

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Phone:

Fax:

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