

Request for Adult (18+) Medical Oncology Referral / Consultation

IF THIS IS AN URGENT REQUEST, PLEASE CALL THE OFFICE DIRECTLY AT 518-243-4762

WHEN REQUESTING A REFERRAL / CONSULTATION:

COMPLETE THIS FORM AND FAX TO 518-243-4074 WITH THE FOLLOWING:

- PATIENT DEMOGRAPHICS
- OFFICE NOTES
- PATHOLOGY STUDIES*
- INSURANCE INFORMATION
- RADIOLOGY IMAGES*
- LABORATORY STUDIES*

* FOR STUDIES COMPLETED OUTSIDE ELLIS MEDICINE, PLEASE INDICATE LOCATION WHERE PERFORMED:

REFERRING PROVIDER INFORMATION

REFERRING PROVIDER: _____ TODAY'S DATE: _____

REFERRING PHONE: _____ REFERRING FAX: _____

PATIENT INFORMATION

PATIENT NAME: _____ DATE OF BIRTH: _____

PATIENT ADDRESS: _____

PATIENT HOME PHONE: _____ WORK/CELL: _____

PRIMARY INSURANCE: _____ ID #: _____

SECONDARY INSURANCE: _____ ID #: _____

DIAGNOSIS / REASON FOR CONSULTATION

<p>OFFICE USE ONLY: APPOINTMENT DATE: _____</p> <p>APPOINTMENT TIME: _____</p> <p>PROVIDER: _____</p> <p>COMPLETED BY: _____</p> <p>NOTES: _____</p> <p>OFFICE WILL CALL PATIENT TO SCHEDULE APPOINTMENT AND RETURN THIS FORM VIA FAX ONCE APPOINTMENT IS SCHEDULED</p>
