Specialty Service Referral
Oncology

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REFERRING PROVIDER

Name _____ Phone _____ Fax _____

Reason for Referral _____

_____ Date _____

PATIENT INFORMATION

Name _____ Date of Birth _____ Social Security Last 4# _____

Address _____ City _____ State/Zip _____

Phone _____ County _____

Insurance Carrier Primary _____ Secondary _____

If HMO/POS or United Healthcare insurance plan, referral authorization to be obtained by referring office. Authorization # _____

Work Related ❑ Yes ❑ No If yes, Employer _____ Contact _____

Work Comp Carrier _____ Contact _____

INFORMATION NEEDED
Please include all the information below.

- ❑ Provider Notes
- ❑ Procedure Reports
- ❑ Appropriate Laboratory Reports
- ❑ Appropriate Imaging Reports
- ❑ Medication and Allergy Lists

Please indicate specialty needed for referral.

_____

Preferred Provider

_____

Appointment Urgency

- ❑ First available
- ❑ Urgent

REFERRING RESPONSE

❑ Patient Scheduled

Provider _____ Date _____ Time _____

Comment _____

❑ Patient NOT Scheduled

Additional Information Required _____

Other Reason _____