RAPID REFERRAL FORM

Date: _____/_____/_____

From:_____ ☐ Routine ☐ Urgent

Sender's Fax #:_____ Sender's Phone #:_____

TO REFER OR SCHEDULE A NEW PATIENT:

1. **FAX** this form to the number listed below and **include all pertinent records:**

   Broomall office: 610.492.5853
   Brinton Lake office: 484.841.6433

2. **CALL** patient scheduler at the numbers listed below:

   Broomall office: 610.492.5900
   Glen Mills office: 610.492.5905

(Provide Return Fax number for response)

To be completed by CMOH staff
Date of scheduled appointment: _____

PATIENT PROFILE

Demographics sheet attached? ☐ yes ☐ no (If yes, please be sure all information below is included.)

Patient Name: _____ DOB: ____/_____/_____ Sex: ☐M ☐F
Last First MI

Patient Address:_____
Street City Street Zip

Home Phone: ( ) _____ Cell Phone: ( ) _____

Social Security Number: _____ Place of Employment: _____

Race:_____ Language preferred: _____

REFERRING PHYSICIAN INFORMATION

Referring Physician: _____ NPI: _____

Diagnosis: _____ *(Please note: Diagnosis is needed to obtain referral if required by insurance)*
(i.e. cancer type, heme, ICD-10 code, other)

INSURANCE

Primary Carrier:_____ Subscriber Name: _____

Policy #: _____ Subscriber DOB: ____/_____/_____

Secondary Carrier: _____ Subscriber Name: _____

Policy #: _____ Subscriber DOB: ____/_____/_____

CONSULTANTS IN MEDICAL ONCOLOGY AND HEMATOLOGY - PHYSICIANS

☐ Medical Oncology and Hematology

☐ Medical Oncology

CMOH Consultants in Medical Oncology and Hematology

In order for our physician to provide you and your patient with the best possible consultation, please attach any of the following information:

1) Physician notes and initial consult notes
2) Recent Lab Work
3) list of medications

CMOH
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Medical Oncology
and Hematology

Thank you for your assistance!
Broomall office: 610.492.5900
Glen Mills office: 610.492.5905