

Roswell Park Hematology Oncology of Niagara
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<u>Patient Information</u>	<u>Consulting Provider Information</u>
Patient Name: _____	Provider Name: _____
Patient Address: _____ _____ _____	Provider Address: _____ _____ _____
Date of Birth: _____	Phone Number: _____
Home Phone Number: _____	Fax Number: _____
Work Phone Number: _____	Needs Referral: <input type="checkbox"/> Yes <input type="checkbox"/> No
Cell Phone Number: _____	Referral # _____
Insurance Carrier: _____	
Insurance ID #: _____	

PLEASE ANSWER THESE QUESTIONS:

1. What is the patient's hematology-oncology problem/chief complaint?

2. Pertinent past medical history and lab result?

**** Please fax this form to (888)-847-3060 along with pertinent medical records: Clinic/hospital notes test, imaging results, and pertinent consultations. Please include any necessary insurance referral authorizations.**

Thank you

Consulting Provider Signature: _____ Date/Time: _____