Columbus Oncology& Hematology Associates

An Ohio Oncology & Hematology, LLC Practice

810 Jasonway Avenue, Columbus, Ohio 43214

www.COAinc.net

PATIENT REFERRAL REQUEST

Please complete this form in full and fax to **(614) 437-0606** with requested documentation – see below
Questions about new patient referrals can be directed to (614) 442-3130 (ask for Janine)

Today's Date: _____/_____/_____

Patient Name: _____ DOB: _____/_____/_____ SSN#: _____-_____-_____
REQUIRED

Patient Address: _____
Street City State Zip Code

Preferred Contact #: (_____)_____ Alternate Contact #: (_____)_____

Primary Insurance: _____ ID #: _____ Group #: _____

Secondary Insurance: _____ ID #: _____ Group #: _____

Reason for Consult/Diagnosis (*PLEASE BE SPECIFIC*): _____

Please circle preferred Physician: First Available / No Preference

Sonia Abuzakhm MD	Scott Blair MD	Shabana Dewani MD
Christopher George MD	Andrew Grainger MD	Joseph Hofmeister MD
Peter Kourlas MD	Erin Macrae MD	Nse Ntukidem MD
Emily Saul DO	Thomas Sweeney MD	

Referring Physician: _____ Referring Phone: (_____)_____

Referring Contact Name: _____ Referring Fax: (_____)_____

Primary Care Physician: _____

Comments: _____

_____

PLEASE PROVIDE THE FOLLOWING INFORMATION WITH YOUR REFERRAL

Progress/Office Notes	**Pathology**	**Patient Insurance Cards**
Operative Reports	**Blood work**	**Patient Demographics**
Recent Scans	**Hospital Discharge Summary**	

Thank you for referring your patient to our practice!

If this referral is emergent, please have the patient's physician contact our office at (614) 442-3130