



Columbus Oncology & Hematology Associates

810 Jasonway Avenue, Columbus, Ohio 43214

www.coainc.cc

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	
Home Phone #: (____) _____		Alternate Phone #: (____) _____		
Primary Insurance: _____	ID #: _____	Group #: _____		
Secondary Insurance: _____	ID #: _____	Group #: _____		
Reason for Consult/Diagnosis (<i>PLEASE BE SPECIFIC</i>): _____				

Please circle preferred Physician: First Available / No Preference

Sonia Abuzakhm MD
 Christopher George MD
 Peter Kourlas MD
 Emily Saul DO

Scott Blair MD
 Andrew Grainger MD
 Erin Macrae MD
 Thomas Sweeney MD

Shabana Dewani MD
 Joseph Hofmeister MD
 Nse Ntukidem 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
Operative Reports
Recent Scans

Pathology
Blood work
Hospital Discharge Summary

Patient Insurance Cards
Patient Demographics

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