



Columbus Oncology & Hematology

Serving Ohio Since 1987

810 Jasonway Ave.
Columbus, Ohio 43214-4359
Phone: (614) 442-3130
Fax: (614) 442-3145

PATIENT REFERRAL REQUEST

Please complete this form and fax to **(614) 437-0606** with requested documentation. For any additional questions, please contact our office at (614) 442-3130 and request to speak with one of our New Patient Referral Coordinators. Thank you.

Today's Date: _____

Patient Name: _____ DOB: _____ SSN#: _____

Patient Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Alt Phone: _____

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

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

Reason for Consult/Diagnosis (PLEASE BE SPECIFIC):

Please select your Physician(s) of preference:

	Sonia Abuzakhm, MD	Christopher George, MD	Kavya Krishna, MD
First Available	Scott Blair, MD	Andrew Grainger, MD	Erin Macrae, MD
No Preference	Jarred Burkart, MD	Joseph Hofmeister, MD	Nseobong Ntukidem, MD
	Shabana Dewani, MD	Elizabeth Kander, MD	Emily Saul, DO
		Peter Kourlas, MD	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 (6-12 mos) | 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