HOC

Hematology Oncology Center

A DIVISION OF AMERICAN ONCOLOGY PARTNERS, P.A.

REFERRAL REQUEST

Please complete all fields and fax this to: (440) 581-7801
If you have questions, please call the referral line: (440) 316-5000
A PDF version is available to download from: **ElyriaHOC.com**

Patient Name: _____ **DOB:** _____ **Today's Date:** _____

Patient Address: _____
Street Address City State Zip

Preferred Phone #: ( ) _____ **Alternate Phone #:** ( ) _____

Language: _____ **Race:** _____ **Ethnicity:** _____

SS #: _____ **Primary Insurance:** _____

Diagnosis/Reason for Consultation: _____

Preferred Physician

Medical Oncologist/Hematologists: (Please circle a preferred physician or **First Available**)

First Available

Ruben Escuro, MD Patrick Litam, MD Jay Sidloski, DO

Referring Physician: _____ **Staff Contact:** _____

Phone: _____ **Fax:** _____

Comments: _____

Primary Physician, if not referring: _____

In order to better serve the patient, please provide us with the following information:

- ____ Patient Insurance Card(s)
- ____ Recent Scans
- ____ Progress/Office Notes
- ____ Operative Reports
- ____ Patient Demographics
- ____ Pathology
- ____ Photo ID
- ____ Blood Work

FOR OFFICE USE ONLY

Appointment date and time: _____ **Doctor:** _____

Notes: _____

_____

_____