HEMATOLOGY
ONCOLOGY CLINIC
A DIVISION OF AMERICAN ONCOLOGY PARTNERS, P.A.

NEW PATIENT REFERRAL FORM

Call or Fax Your Referral

ALEXANDRIA • Phone: (318) 579-7032
BATON ROUGE & ZACHARY • Phone: (225) 767-0822 • **Referral Fax:** (225) 761-3886

☐ **MEDICAL ONCOLOGY** ☐ **HEMATOLOGY**

☐ Michael Castine, III, MD ☐ Pavani Ellipeddi, MD ☐ Christopher McCanless, MD

☐ Gerald Miletello, MD ☐ 1st Available

LOCATION:

☐ **ALEXANDRIA** | 605 Medical Center Drive, Suite B, Alexandria, LA 71301

☐ **BATON ROUGE** | 8585 Picardy Ave., Suite 110, Baton Rouge, LA 70809

☐ **ZACHARY** | 1673 E. Mount Pleasant Road, Suite F-102, Zachary, LA 70791

REASON FOR CONSULT (MANDATORY) _____

Urgency: ☐ ASAP (24 hrs.) ☐ Routine (48-72 hrs.) ☐ 1-2 Weeks

Patient Name _____

Date of Birth _____ Phone _____

Cell _____ Referring Doctor _____

Phone # _____ Fax # _____

Primary Care Provider *(if different than the referring doctor)* _____

Phone # _____ Fax # _____

Primary Insurance Carrier: _____

Name of primary policy holder: _____

Policy#/Group ID: _____

Thank you for entrusting your patients' care to Hematology Oncology Clinic.

*We appreciate your confidence in HOC to care for your patients. Thank you for taking the time to send all required paperwork at time of referral (**recent office notes, lab, radiology reports and ALL pathology**) so we may see your patient as soon as possible. Please contact the office if you have any questions regarding necessary paperwork.* ***Thank you.***