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: ______________________________

Date of Birth: ____________________ Today's Date: ____________________

Patient Address: ______________________________

Preferred Phone #: ____________________ Alternate Phone #: ____________________

Language: ______________ Race: ______________ Ethnicity: ______________

SS#: ____________________ Primary Insurance: ____________________

Diagnosis/Reason for Consultation: ______________________________

Preferred Physician
Medical Oncologist/Hematologists: (Please select a preferred physician or First Available)

☐ **First Available** ☐ Xuan Huang, MD, PhD ☐ 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) ☐ Operative Reports ☐ Photo ID
☐ Recent Scans ☐ Patient Demographics ☐ Blood Work
☐ Progress/Office Notes ☐ Pathology

FOR OFFICE USE ONLY

Appointment date and time: ____________________ Doctor: ____________________

Notes: ______________________________

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