CookChildren's

HEMATOLOGY-ONCOLOGY NEW PATIENT REFERRAL / INTAKE FORM

Date of Referral: _____ Time: _____ Records Status: ◉ Records Attached ○ Records in Athena

Referral desk: 682-885-4542 Referral Fax: 682-885-2316

Please complete Gray area of form

Patient Full **LEGAL** Name: _____ Sex: _____

Date of Birth: _____ Age: _____ **Patient** Social Security #: _____

Address: _____ (Street or PO Box) _____ (City) _____ (State) _____ (Zip)

Primary Contact #: _____ (Type) _____ Secondary Phone #: _____ (Type) _____

Preferred Language: _____ Race/Ethnicity _____ Religion: _____

Caller Name: _____ **Referring Physician**: _____

Office Number _____ Back Line #: _____ Fax #: _____

Does Referring Physician want a call back? _____ Call back#: _____ (Type) _____

Reason for Referral: _____

Signs/Symptoms: _____

Is it necessary for patient to be seen within 5-7 business days from referral date? ❑ Yes ❑ No

Has Referring Physician notified the family of the Hematology/Oncology Referral? ❑ Yes ❑ No

Primary Care Physician: _____ Phone #: _____

H/O PROVIDER ASSESSMENT: Reviewed by: _____(Provider name)

❑ Referral appropriate for Hematology/Oncology Location: ❑Ft.Worth ❑GPV ❑Any ❑Other: _____

Type of provider to see: ❑Oncology ❑Hematology ❑SCT ❑Other _____

Urgency of appointment: ❑ASAP ❑1 week ❑2 weeks ❑Next Available ❑Other _____

Special Instructions: _____

Additional Records: _____

❑ Patient **does not** need to be seen by Hem-Onc at this time and referring physician given following information:

_____

_____

Patient Lives with: _____ Relationship: _____

Primary Contact #: _____ (Type) _____ Secondary Phone #: _____ (Type) _____

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Patient Name: _____ **DOB:** _____

INSURANCE INFORMATION

PRIMARY PCP Referral Required? ____ Spoke to: _____ Date: _____

Name of Insurance _____ Phone: _____

ID#: _____ Group Name: _____ Group #: _____ _____ Plan Type

Claim Mailing Address: _____ _____ ____ _____

Street or PO Box City State Zip

Designated Primary Care Physician: _____ Phone: _____

Policy Holder's Name: _____ Patient's Relationship: _____

Policy Holder's DOB: _____ Policy Holder's SS# Number: _____

Policy Holder's Employer: _____

SECONDARY PCP Referral Required? ____ Spoke to: _____ Date: _____

Name of Insurance _____ Phone: _____

ID#: _____ Group Name: _____ Group #: _____ _____ Plan Type

EMERGENCY CONTACT

Someone who **does not** live in the same household

Name: _____ Relationship to Patient: _____

Primary Contact #: _____ _____ Secondary Phone #: _____ _____

Type Type

FRONT OFFICE USE:

Appointment scheduled: ❑ Ft. Worth ❑ GPV ❑Other _____

Date: _____/_____/_____ Time: _____:_____ am/pm

revised 10/24/16