



### Appointment Referral

Please complete and submit by fax **(864) 603-6161**.

For questions, please contact the Bon Secours Hematology & Oncology Intake Nurse at **(864) 603-6331**.

#### Referring Physician/Practice Information

Physician's Name: \_\_\_\_\_ Practice: \_\_\_\_\_

Phone : (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Fax : (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Office Contact Name: \_\_\_\_\_

#### Preferred Bon Secours Hematology/Oncology Physician: First Available

- Dr. Hal Crosswell, AYA (Ages 15-39)     Dr. Stephen Dyar     Dr. David Griffin     Dr. Sharif Khan
- Dr. Fahd Quddus     Dr. Robert Siegel     Dr. Alex Yang     Dr. Julie Eggert (CRiSP)

#### Referral Details

Routine     URGENT – Explanation: \_\_\_\_\_

Reason/Diagnosis: \_\_\_\_\_

Is this patient being referred for transplant consultation?  YES     NO

Is this patient being referred for a Clinical Trial?  YES - Name of study: \_\_\_\_\_     NO

#### Patient Information

Name: \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Sex: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Marital Status: \_\_\_\_\_ Race: \_\_\_\_\_

Primary Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Secondary Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Email: \_\_\_\_\_@\_\_\_\_\_

Primary Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_

#### Insurance Subscriber Information (if different than patient)

Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Employer: \_\_\_\_\_

PLEASE SEND ALL OFFICE NOTES AND LABS ASSOCIATED WITH THE REFERRING DIAGNOSIS