Phone: 386.755.1655 Fax 386.755.2330 | Phone: 386.755.0601 Fax 386.755.0602

PLEASE CHECK WHO THE PATIENT IS BEING REFERRED TO:

Medical Oncology: ______ Dr. Waseem Khan ______ Dr. Vernon Montoya

Radiation Oncology: ______ Dr. Mark E. Thompson

Today's Date ____
Referring Physician ____
Physician Phone ______________________ Physician Fax______________________
PCP (if different) ____

Patient's Name ______________________________ DOB ______________
Patient Address____
SSN ______________ Patient Phone Number(s) ______________________

Patient Diagnosis ____
Referral for ____

Primary Insurance ____
ID# ______________________ Group# ____________________
Name of insured if other than patient ______________________ Date of Birth __________

Secondary Insurance ____
ID# ______________________ Group# ____________________
Name of insured if other than patient ______________________ Date of Birth __________

Please include office notes, pathology, labs, and all recent scans.
Please also send a copy of the patient's insurance card with this referral form.

The patient will be asked to bring any pertinent films/discs to their initial consultation.

NOTES:
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Hematology/Oncology: 289 SW Stonegate Terrace Suite 103, Lake City, FL 32024 Phone: 386.755.1655 Fax 386.755.2330
Radiation Oncology: 4520 W US Hwy 90, Lake City, FL 32055 Phone: 386.755.0601 Fax 386.755.0602