Print Reset Form Fields

# NEW PATIENT REFERRAL FORM
# ADULT HEMATOLOGY

MUSC
MEDICAL UNIVERSITY of SOUTH CAROLINA

Referral to: _____

Patient Name: _____ DOB: _____

SS#: _____ Address: _____

Ph #: _____ _____

Ph #: _____ Email: _____

Alternate Contact Ph #: _____Relation to Patient: _____

☐ Self-Pay ☐ MEDICAID ID#_____ ☐ MEDICARE ID #_____

☐ Insurance Provider Name _____ ID#_____

Policy/Group# _____ Phone # from back of card_____

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Referring Physician:_____ Specialty:_____

Office Address:_____ Ph#: _____ Fax#: _____

_____

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Reason for Referral: _____

Diagnosis: _____

Additional Patient History: _____

Please attach the following records:

| PLEASE ATTACH THE FOLLOWING RECORDS | | | | | |
|---|---|---|---|---|---|
| ☐ Office Notes | ☐ Radiology Reports | ☐ *Operative Note(s) | ☐ *Pathology Report(s) | ☐ *All Recent Labs Results | ☐ Copy of Insurance Card |

Completed by: _____ Ph#:_____ Date:_____

Please fax the complete packet with all necessary information to 843-792-0644 (Referral Form plus applicable records). Once your information has been received, it will be reviewed and you will be contacted about your request to see a benign hematologist.

Thank you.

| MULTIDISCIPLINARY SPECIALTY | HCC NEW PATIENT INTAKE FAX # |
|---|---|
| **Hematology** | **(843) 792-0644** |