

# Markey Hematology and BMT Clinic

800 Rose Street

Lexington, KY 40536

Phone: 859-257-6006 Fax: 859-323-5822

## Hematology/BMT REFERRAL FORM

	<b>Please Schedule (select all that apply):</b> <input type="checkbox"/> Routine <input type="checkbox"/> Urgent (72 hours) <input type="checkbox"/> Critical (24 hours)		
	<b>Referring Provider's Name:</b>	<b>Phone:</b>	<b>Fax:</b>
Type of REFERRAL	<input type="checkbox"/> New <input type="checkbox"/> 2nd Opinion <input type="checkbox"/> Transfer of Care <input type="checkbox"/> Hospital Discharge Diagnosis _____		
PATIENT INFORMATION	Patient Full Legal Name:		DOB:
	<b>**Please include a copy of the patients insurance cards and ID with Referral**</b>		
	Preferred Phone:		Best time to call:
	Special Patient Considerations:		
	Patient Insurance Information:		
	Patient's Primary Care Provider:	Phone:	Fax:
GENERAL INFORMATION	Please send the following:		
	<input type="checkbox"/> Recent labs <input type="checkbox"/> Pertinent Imaging Reports <input type="checkbox"/> Medication List <input type="checkbox"/> Problem List <input type="checkbox"/> Allergies <input type="checkbox"/> Pathology <input type="checkbox"/> Chemo Summary <input type="checkbox"/> Recent labs <input type="checkbox"/> <b>Most recent</b> office visit		
	Is patient aware of his/his diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No Is patient aware of his/her referral? <input type="checkbox"/> Yes <input type="checkbox"/> No		

## PROVIDER REFERRAL CONFIRMATION (Internal MHP Use Only)

	Records Triage by:	
	Referral Accepted? <input type="checkbox"/> Yes <input type="checkbox"/> No: Why? _____	
REFERRAL CONFIRMATION	<b>Malignant</b> Does the patient need to be seen sooner than <b>7 days</b> ? <input type="checkbox"/> Yes: _____ <input type="checkbox"/> No	<b>Benign Patient</b> Does the patient need to be seen sooner than 14 days? <input type="checkbox"/> Yes: _____ <input type="checkbox"/> No
	Appointment Scheduled with:	Date & Time:
	<input type="checkbox"/> Patient refused scheduling <input type="checkbox"/> Patient prefers a later date	
	Person completing confirmation:	Date of Confirmation: