Markey Hematology and BMT Clinic

800 Rose Street
Lexington, KY 40536
Phone: 859-257-6006 Fax: 859-323-5822

Hematology/BMT REFERRAL FORM

Please Schedule (select all that apply):

☐ Urgent ☐ Routine ☐ Referring physician called, Date/Time:_____

Appointment with Specific Physician listed:_____ ☐ First Available with any Physician

Referring Provider's Name:	**Phone:**	**Fax:**

Type of REFERRAL

☐ Evaluation consultation with treatment Referral recommendations that primary care physician will continue to follow

☐ Specialist to Specialist*–Secondary *Send copy of this referral to patient's primary care physician.

☐ Evaluation consultation with assumed care for this Condition: _____

☐ Other (designate)_____

☐ Evaluation consultation with treatment recommendations and shared care.

PATIENT INFORMATION

Patient Full Legal Name:		DOB:
****Please include a copy of the patients insurance cards and ID with Referral****		
Preferred Phone:	Best time to call:	
Special Patient Considerations:		
Patient Insurance Information:		
Patient's Primary Care Provider:	Phone:	Fax:

GENERAL INFORMATION

Reason for Referral (*Clinical Question*):

Comments/Considerations Related to Clinical Question: **Please include recent labs, pertinent imaging reports, medication list, problem list, allergies, and relevant clinical notes. **

Patient aware of reason for referral? ☐ Yes ☐ No: Explain _____

PROVIDER REFERRAL CONFIRMATION (Internal MHP Use Only)

Records Triaged by:

REFERRAL CONFIRMATION

Referral Accepted? ☐ Yes ☐ No - **Reason**:

Time Frame patient needs to be seen:

Request for additional supporting clinical information (please detail):

Appointment Scheduled with:	**Date & Time:**

☐ **Patient refused scheduling** ☐ **Patient prefers a later date**

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	Person completing confirmation:	**Date of Confirmation:**