

Rapid Fax Referral Form



Date: ____/____/____

From: _____

Sender's Fax #: _____

Sender's Phone #: _____

☐ Check box if you want this form faxed back to sender

To refer or schedule a new patient:

1. **FAX** this form to the number listed below and **include all pertinent records:**

(540) 450-1791

OR

2. **CALL** patient scheduler at the number listed below:

(540) 662-1108

We request that you call us with any new oncology patient referrals.

Patient Profile

Patient Name: _____ DOB: ____/____/____ Sex: ☐ M ☐ F
Last First MI

Patient Address: _____
Street City State Zip

Home Phone: () _____ Work Phone: () _____

Social Security Number: _____ Cell Phone: () _____

Referring Physician Information

Referring Physician: _____ Phone: _____ Fax: _____

Diagnosis: _____ NPI: _____
(i.e. cancer type, heme, other)

Insurance

Primary Carrier: _____ Subscriber Name: _____

Policy #: _____ Subscriber DOB: ____/____/____

Secondary Carrier: _____ Subscriber Name: _____

Policy #: _____ Subscriber DOB: ____/____/____

Shenandoah Oncology Physicians

Medical Oncology and Hematology

☐ **First Available** ☐ Bill A. Houck, M.D. ☐ William B. Major, M.D. ☐ Nicholas W. Gemma, M.D.
☐ Richard M. Ingram, M.D. ☐ William A. Houck, III, M.D. ☐ Lee P. Resta, M.D. ☐ L. Morgan O'Brien, M.D.

Appointment Date: ____/____/____ Time: _____ Patient Notified: _____

Physician: _____ Office Location: _____