Nebraska Hematology-Oncology, P.C.
4004 Pioneer Woods Drive | Lincoln, NE 68506
p: 402.484.4900 | f: 402.817.0189
www.yourcancercare.com

PATIENT REFERRAL FORM

NHO Use Only

☐ Patient Scheduled
Appt. Date: _____/_____/_____
Check-In:___:_____ Appt.: ___:_____
Doctor: _____
☐ Patient Not Scheduled
☐ Patient Refused: _____
☐ Attempted to Contact/Schedule
x1_____
x2_____

Today's Date: _____/_____/_____

Patient's Full Name: _____

Patient's Date of Birth: _____/_____/_____

Patient's SSN: _____

Patient's Address: _____

City: _____ State: _____ ZIP: _____

Email: _____

Preferred Language: _____ Interpreter Required: yes no

Phone Number: (_____)_____ Alternate Phone Number: (_____)_____

Referring Physician: _____ Phone: (____)_____ Fax: (____)_____

Patient will call NHO to schedule appointment* ☐ Patient requests NHO to call to schedule appointment ☐

***Please wait at least 24 hours from the time this form is submitted before calling to schedule an appointment**

Patient's PCP: _____

Other Physicians Caring for Patient: _____

Has Patient Been Seen at Hospital?: yes no If yes, which hospital: _____

Insurance Plan: _____ Policy Number: _____

Reason for Visit/Diagnosis: _____ ICD 10 Code: _____

Test(s) Completed:

☐ Colonoscopy ☐ Upper Endoscopy ☐ Laboratory ☐ Biopsy
☐ Pathology ☐ Radiology ☐ Other: _____

Physician Preference (Choose One):

☐ Eric J. Avery, MD ☐ Madhu V. Midathada, MD ☐ Kailash Mosalpuria, MD, MPH, FACP
☐ Irfan Vaziri, MD ☐ First Available

Please fax the information below to **402.817.0189**, Attn: NP Coordinator or email to **medrecords@yourcancercare.com**

Completed Referral Form | Office Notes from Last 2 Years | Labs from Last Year

Diagnostic Testing | Demographic Information and Insurance Cards

Thank you for your referral!
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