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'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:

☐ Eric J. Avery, MD ☐ Madhu V. Midathada, MD ☐ Kailash Mosalpuria, MD, MPH, FACP
☐ Matthew P. Shupe, MD ☐ Irfan A. 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!
Nebraska Hematology-Oncology, P.C.