CARTI MEDICAL ONCOLOGY/HEMATOLOGY

FAX To: 501.537.8787

Provider/Clinic: _____

Scheduling: 501.537.8650 or 1.800.482.8561 • CCCReferrals@CARTI.com

PATIENT REFERRAL

PATIENT INFORMATION — Please Print **MRN or SSN** _____

NAME_____ DOB _____/_____/_____

ADDRESS_____ CITY_____ STATE/ZIP_____

PHONE _____

REASON FOR REFERRAL

❍ ONCOLOGY ❍ HEMATOLOGY ❍ CRITICAL LAB VALUE

DIAGNOSIS _____

PREFERRED CARTI PHYSICIAN _____ ❍ FIRST AVAILABLE PHYSICIAN

INSURANCE

❍ INSURED (PLEASE INCLUDE)_____

❍ MEDICARE ❍ MEDICAID ❍ SELF PAY

TO REFER, PLEASE INCLUDE THE FOLLOWING

Please have patient bring CD to visit

❍ **Demographic Sheet** ❍ OP/Procedures ❍ Radiology

❍ H & P/Office Note ❍ Current Med List ❍ Labs (last 2 visits)

❍ Pathology

NOTES: _____

_____

Note: You will be notified when the patient has been scheduled.

* Appointments for non-emergent hematology patients may take 2-4 weeks to schedule based on review of records.