HORIZON ONCOLOGY
& RESEARCH CENTER
A VERDI PRACTICE

HORIZONONCOLOGYCENTER.COM
PHONE 765.446.5111
FAX 765.838.0972

ONCOLOGY REFERRAL FORM

LOCATION

1345 Unity Place, Suite 345
Lafayette, IN 47905

PATIENT INFORMATION

Thank you for the referral. So we can best serve your patient, please send all pertinent medical records, demographics, and copies of current insurance. Fax completed form and documents to (765) 838-0972.

Today's Date: Appointment Type: ☐ Oncology ☐ Hematology

Patient's Last Name:	Patient's First Name:	DOB:

Sex: ☐ M ☐ F	Patient's Phone Number:

Insurance: ☐ Commercial ☐ Medicare ☐ Medicare Advantage ☐ Other

Name of Insurance Provider:

Diagnosis:

Is patient presently symptomatic? ☐ Yes ☐ No

If Yes, Date: List of symptoms:

Has this patient ever been evaluated by any Oncologist/Hematologist? ☐ Yes ☐ No

If Yes, Name:

Location: When:

REFERRING PROVIDER

Physician's Name:	NPI:

Office Contact Name:	Phone #:	Fax #:

Email: