Markey Hematology and BMT Clinic

800 Rose Street
Lexington, KY 40536
Phone: 859-257-6006 Fax: 859-323-5822

Hematology/BMT Referral Form

Please Schedule (select all that apply):
☐ Routine ☐ Urgent (72 hours) ☐ Critical (24 hours)

Referring Provider's Name:	**Phone:**	**Fax:**

Type of Referral

☐ New ☐ 2nd Opinion ☐ Transfer of Care ☐ Hospital Discharge

Diagnosis _____

Patient Information

Patient Full Legal Name:		DOB:
****Please include a copy of the patients insurance cards and ID with Referral****		
Preferred Phone:	Best time to call:	
Special Patient Considerations:		
Patient Insurance Information:		
Patient's Primary Care Provider:	Phone:	Fax:

General Information

Please send the following:

☐ Recent labs ☐ Pertinent Imaging Reports ☐ Medication List ☐ Problem List ☐ Allergies
☐ Pathology ☐ Chemo Summary ☐ Recent labs ☐ **Most recent** office visit

Is patient aware of his/his diagnosis? ☐ Yes ☐ No
Is patient aware of his/her referral? ☐ Yes ☐ No

Provider Referral Confirmation (Internal MHP Use Only)

Records Triaged by:

Referral Confirmation

Referral Accepted? ☐ Yes ☐ No: Why?_____

Malignant	**Benign Patient**
Does the patient need to be seen sooner than **7 days**?	Does the patient need to be seen sooner than 14 days?
☐ Yes: _____	☐ Yes: _____
☐ No	☐ No

Appointment Scheduled with:	Date & Time:
☐ Patient refused scheduling ☐ Patient prefers a later date	
Person completing confirmation:	Date of Confirmation: