



The Choice for Oncology & Hematology

### REFERRAL REQUEST

Please complete all fields and fax this form to (614) 383-6155 or use the Secure Form Submission Tool on our website. If you have questions, please call the referral line: (614) 383-6475.

Copies of this form may be downloaded from our website: www.zangcenter.com

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Patient Address: \_\_\_\_\_  
Street Address City State Zip

Preferred Phone #: ( ) \_\_\_\_\_ Alternate Phone #: ( ) \_\_\_\_\_

Language: \_\_\_\_\_ Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

SS # (required): \_\_\_\_\_ Primary Insurance: \_\_\_\_\_

Email Address: \_\_\_\_\_ Insurance Referral Required? Y N

Diagnosis/Reason for Consultation: \_\_\_\_\_

#### Preferred Physician:

##### Medical Oncologists/Hematologists

- |                      |                         |                      |                      |
|----------------------|-------------------------|----------------------|----------------------|
| Tarek A. Chidiac, MD | Patrick C. Elwood, MD   | Mark H. Knapp, MD    | Jeanna L. Knoble, MD |
| Sameh Mikhail, MD    | Jerry W. Mitchell, MD   | Timothy D. Moore, MD | Taral Patel, MD      |
| Jorge Rios, MD       | Mark L. Segal, MD       | Kothai Sundaram, MD  | Mark E. Thompson, MD |
| Emily Whitman, MD    | Jeffrey Zangmeister, MD |                      |                      |

##### Gynecologic Oncologists

- |                     |                        |
|---------------------|------------------------|
| Luis Vaccarello, MD | Dennis C. DeSimone, DO |
|---------------------|------------------------|

Referring Physician: \_\_\_\_\_ Staff Contact: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Comments: \_\_\_\_\_

Primary Physician, if not referring: \_\_\_\_\_

Does the patient need an interpreter? Y N Language: \_\_\_\_\_

#### In order to better serve the patient, please provide us with the following information:

- |  |   |                                     |
|--|---|-------------------------------------|
| <input type="checkbox"/> Patient insurance card(s) | <input type="checkbox"/> Operative reports    | <input type="checkbox"/> Photo ID   |
| <input type="checkbox"/> Recent scans              | <input type="checkbox"/> Patient demographics | <input type="checkbox"/> Blood work |
| <input type="checkbox"/> Progress/Office notes     | <input type="checkbox"/> Pathology            |                                     |

#### FOR OFFICE USE ONLY

Appointment date and time: \_\_\_\_\_ Doctor: \_\_\_\_\_

Notes: \_\_\_\_\_  
\_\_\_\_\_