Surinder Vohra MD
FAX 866-685-8271
PHONE 717-845-7373

Oncology/Hematology Referral

PATIENT LAST NAME:	PATIENT FIRST NAME:	DOB: SS #:
PHONE NUMBER:	ADDRESS	
DIAGNOSIS:		

****PLEASE ATTACH COPY OF FRONT AND BACK OF INSURANCE CARD****

PRIMARY INSURANCE	SECONDARY INSURANCE
ID NUMBER:	ID NUMBER:

HAS THIS INDIVIDUAL EVER BEEN EVALUATED BY ANY ONCOLOGIST/HEMATOLOGIST?

☐YES ☐NO IF YES, NAME:
LOCATION: APPROX DATE(S):

REFERRING PROVIDER

NAME:	PHONE#	FAX:
OFFICE CONTACT NAME:		

PRIMARY CARE PROVIDER

NAME:	PHONE#	FAX:
PRACTICE NAME:		

In order to expedite your request, please attach the following documents and fax to 866-685-8271:

☐ Most recent office notes
☐ Any relevant labs/scans not found in Memorial PowerChart or Wellspan Epic
☐ Copy of insurance card (Front and Back)

We will contact the patient to schedule appointment and notify your office of date and time below

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Appointment Confirmation

☐ Patient Scheduled ☐ Patient Not Scheduled

Date/Time ________________________________ Reason ________________________________