OFFICE USE ONLY
Appointment Date & Time:

Provider: _____
Coordinator: _____
Comments:

UTHSC COLLEGE OF MEDICINE

MALIGNANT HEMATOLOGY PROGRAM

920 Madison Avenue
Memphis, TN 38163
Phone: 901-448-3469
Fax: 901-448-6297
Attn: Cathy Cole

Referral Date:

MALIGNANT HEMATOLOGY & CELL THERAPY REFERRAL FORM

REFERRING PROVIDER NAME: _____ **DIRECT PHONE #:** _____

OFFICE CONTACT: _____ **Email:** _____

PHONE #: _____ **Extension:** _____

FAX # _____ **(The patient's appointment information will be faxed to you).**

Please Select Referral Reason: ○ **Allogeneic Transplant** ○ **Autologous Transplant** ○ **CAR-T Cell Therapy**
(Check all that apply) ○ **Second Opinion on Disease Management**

REQUIRED DOCUMENTATION

ATTENTION- PATIENTS WILL NOT BE SCHEDULED UNTIL ALL DOCUMENTS HAVE BEEN RECEIVED.

○ Insurance Card/s Copy Front and Back	○ Demographic Page
○ Recent Progress Note with Oncology History	○ ORIGINAL Pathology of Cancer
○ Chemotherapy/ Radiation History (if applicable)	○ Most Recent Labs
○ Diagnostic Imaging Reports (PET/CTs) (Last 3 Months)	○ Bone Marrow Biopsy Report

PATIENT INFORMATION

Name:	**DOB:**	**SSN:**
Address:	**City/State:**	**Zip:**
Home Phone:	**Cell Phone:**	**Work Phone:**
Primary Insurance:	**Secondary Insurance:**	**Tertiary Insurance:**
Member ID:	**Member ID:**	**Member ID:**
Insurance Provider #	**Insurance Provider #**	**Insurance Provider #**

Primary Diagnosis:	**Secondary Diagnosis:**	**Other:**
ICD10:	**ICD10:**	**ICD10:**
Current Weight:	**Current Height:**	
Previous Stem Cell Transplant: Yes or No	**Location:**	

Fax this page and the REQUIRED records to 901-448-6297.