CONNECTICUT ONCOLOGY GROUP
NEW PATIENT REFERRAL

FAX COMPLETED FORM TO **(860) 358-2222 ATT: PATTY S.**

Any questions, please call (860) 358-2220

Office Preference:

_____ 536 Saybrook Road
Middletown, CT 06457

OR

_____90 Main Street, Suite 102
Centerbrook, CT 06409

REFERRED BY:_____
Phone#:_____
Fax#_____

Patient Name:_____ **DOB**:_____

Address:_____
Phone#:_____ Alt. Phone#:_____

Patient's Insurance:_____ Is Referral Required?_____

Reason for Referral
(Diagnosis):_____

(Please fax all pertinent medical records along with this request)

Has the majority of patient's tests been scheduled at Middlesex Hospital?
Yes _____ No_____ (If **NO**, please indicate name of hospital/facility)_____

Notes/Special
Instructions:_____
_____
_____
___

DO YOU WANT OUR OFFICE TO NOTIFY PATIENT OF THE SCHEDULED APPOINTMENT? YES_____ NO_____
(IF YES, PLEASE MAKE SURE PATIENT IS AWARE OF DIAGNOSIS AND IS EXPECTING OUR CALL)

WE WILL FAX NOTIFICATION OF SCHEDULED APPOINTMENT BACK TO YOUR OFFICE.

APPOINTMENT SCHEDULED WITH DR. _____ ON
_____

AT _____ IN OUR _____ OFFICE.