**** *Consult / Referral Forms are now available on-line at www.collom-carney.com* ****

Collom & Carney Clinic ASSOCIATION

5002 Cowhorn Creek Drive
Texarkana, Tx. 75503
Phone: (903) 614-3009
Fax: (903) 614-3506

Fax received by _____
Date/Time _____

ONCOLOGY / HEMATOLOGY

☐ CONSULT (Request for advice / opinion) or ☐ REFERRAL (Request for management of care)
(Please only select one request)

REQUESTING PROVIDER INFORMATION

Date of Referral _____

Requesting Provider Name	Requesting Provider Address (street, city, state, zip)

Requesting Provider Telephone	Requesting Provider Fax Number	NPI #
( ) -	( ) -	

APPOINTMENT REQUEST

☐ Gary Engstrom, M.D. ☐ Sunil Patel, M.D. ☐ First Available

DIAGNOSIS

PATIENT and INSURANCE INFORMATION

Patient Name (First, Middle Initial, Last)	Gender
	☐ Male ☐ Female

Address	City, State, Zip

Date of Birth (mm/dd/yyyy)	Social Security #
/ /	- -

Home Telephone	Mobile Telephone	Work Telephone
( ) -	( ) -	( ) - xtn

Does patient need an interpreter?	If yes, what language?
☐ Y ☐ N	

Does the patient have medical insurance?	Name of Insurance Company and Plan Number and Group Number
☐ Y ☐ N	

DOCUMENTATION

Please provide consulting physician with all applicable CLINIC NOTES, HISTORY & PHYSICAL, PREVIOUS PROCEDURES, LABORATORY RESULTS, PATHOLOGY REPORTS, RADIOLOGY REPORTS, AND OPERATIVE REPORTS pertinent to the patients visit. Please fax all documentation to (903) 614-3506.
Thank you in advance for the request and your cooperation.

Collom & Carney Clinic INNER OFFICE USE ONLY
Please scan form to Chart Note for Clinic Physician

Patient MR #	Patient ID #