



HEMATOLOGY REFERRAL

Please Fax to: 519-685-8294

Date: -- / -- / --
 YYYY MM DD

Referring Physician (please include name and contact information):

Patient Demographics:

Urgency: Urgent Routine

Please check physician requested and type of referral.

Referral For:

<input type="checkbox"/> General (Benign) Hematology	<input type="checkbox"/> Thrombosis	<input type="checkbox"/> Malignant Hematology
<input type="checkbox"/> Dr. Alan Gob	<input type="checkbox"/> Dr. Michael Kovacs	<input type="checkbox"/> Dr. Uday Deotare
<input type="checkbox"/> Dr. Cyrus Hsia	<input type="checkbox"/> Dr. Alejandro Lazo-Langner	<input type="checkbox"/> Dr. Kang Howson-Jan
<input type="checkbox"/> Dr. Michael Kovacs	<input type="checkbox"/> Dr. Martha Louzada	<input type="checkbox"/> Dr. Cyrus Hsia
<input type="checkbox"/> Dr. Selay Lam		<input type="checkbox"/> Dr. Michael Kovacs
<input type="checkbox"/> Dr. Alejandro Lazo-Langner		<input type="checkbox"/> Dr. Selay Lam
<input type="checkbox"/> Dr. Joy Mangel	Bleeding Disorders Clinic	<input type="checkbox"/> Dr. Alejandro Lazo-Langner
<input type="checkbox"/> Dr. Chai Phua	<input type="checkbox"/> Dr. Chai Phua	<input type="checkbox"/> Dr. Martha Louzada
		<input type="checkbox"/> Dr. Joy Mangel
		<input type="checkbox"/> Dr. Chai Phua
		<input type="checkbox"/> Dr. Anargyros Xenocostas

Reason for Referral:

Attachments (please include clinical documents, medication list, laboratory and imaging studies and pathology reports):

Comments:
