Appt. Date: ________________

Appt. Time: ________________

Provider:___________________

Eastern Connecticut Hematology and Oncology
New Patient Referral Form

Thank you for your referral.
We look forward to partnering with you on the care of your patients.

Date: ______________________________________

Referring Provider: ____________________________ NPI: _________ Phone #: ________________

Patient name: ____ DOB: ___ /___ /______

Address: ____

Phone Number: __________________________Cell Phone Number: __________________________

Insurance: ______________________________Policy Number:______________________________

Insurance: ______________________________Policy Number:______________________________

☐ Dr. Dhami ☐ Dr. Johnson ☐ Dr. Slater (Genetic Counseling) ☐ Dr. Kapur
☐ Dr. Yang ☐ Dr. Changizzadeh ☐ Dr. Bottino ☐ Any Provider

Referral type:

Routine Referral- Diagnosis/ICD Code: ____

Urgent Referral- Diagnosis/ICD Code: ____

Please include the following with the referral:

- Updated demographic information
- Copy of current insurance information (Front and Back)
- Medical records to support diagnosis (office notes, testing, labs, pathology, etc)

Any questions please contact **Tracy Ryan – Intake Specialist** at **(860) 251-9998**.

Referrals can be faxed, sent through our intakes email **referral@echoct.com**, or through our website on our referral page **www.echoassociates.org/referrals.** Our fax number is: **(860) 886-9262**.

Notes:____

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ECHO Office use only:

____Epic Records ____Logged ____Pharmacy ____Outside Records ____Email ____Fax