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 in the care of your patients.

Date: _____

Referring Provider: _____ Phone #: _____

Patient name: _____

DOB: _____ Male_____ Female_____

Address: _____

Email 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

____ Any Provider

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 **Tanya Lent- Intake Coordinator at (860) 251-9998.**
Referrals can be faxed, sent through our intakes email **referral@echoct.com**, or through our website on our referral page **https://echoassociates.org/referrals/**

Notes:

ECHO Office use only:

____Epic Records____Logged____Pharmacy____Outside Records ____Email____Fax