The Vannie E. Cook Jr.
CHILDREN'S CANCER AND HEMATOLOGY CLINIC
101 W. Expressway 83, McAllen, TX 78503
(956) 661-9840 (v) - (956) 661-9841 (f)

Patient Referral Form

Date/Time: _____ **Patient is: waiting / not waiting**

Reason for Referral/Diagnosis:_____

Patient Information

Patient's Name: _____ D.O.B.: _____ M / F

Responsible Party's Name:_____

Address, City, Zip:_____

Contact Numbers: Home: _____Work: _____

Cell/Pager : _____ Other :_____

Insurance Information

Insurance:_____

PCCM Referral: Yes / No (Attach PCCM Referral if Applicable)

Referral Source Information

Referring Physician: _____

Employee Contact: _____

Contact Information: Phone:_____Fax: _____

Lab Information

LABS: Yes: _____ No: _____

*** If labs are not available, we must have a written referral from physician indicating reason for appointment.

PLEASE FAX TO 956-661-9841
CLINIC STAFF WILL CONTACT YOU WITH AN APPOINTMENT.
THANK YOU FOR YOUR REFERRAL.

FOR OFFICE USE ONLY

CLINIC DOCTOR TO COMPLETE:_____Hematology Visit _____Oncology Visit

_____TODAY _____2-3 DAYS _____1 WEEK _____NEXT AVAIL.

Appointment Date: _____ Time:_____ Initials:_____