

Hematology Referral

Please Fax to 519-685-8294

Date _____

Patient Demographics	Referring Physician

Benign		<input type="checkbox"/> Urgent ~ Fax and Call physician's office	
General Hematology <input type="checkbox"/> Dr. Hsia <input type="checkbox"/> Dr. Kovacs <input type="checkbox"/> Dr. Lam <input type="checkbox"/> Dr. Lazo-Langner <input type="checkbox"/> Dr. Mangel	Thrombosis <input type="checkbox"/> No Preference <input type="checkbox"/> Dr. Kovacs <input type="checkbox"/> Dr. Lazo-Langner <input type="checkbox"/> Dr. Louzada Copies of imaging reports are required	Bleeding Disorders <input type="checkbox"/> Dr. Phua	Red Cell Disorders <input type="checkbox"/> Dr. Solh Inherited Red Cell Disorders (sickle cell, thalassemia, spherocytosis, G6PD etc)

Malignant Hematology			<input type="checkbox"/> Urgent ~ Fax and Call physician's office
<input type="checkbox"/> Dr. Deotare <input type="checkbox"/> Dr. Howson-Jan <input type="checkbox"/> Dr. Kovacs <input type="checkbox"/> Dr. Lam	<input type="checkbox"/> Dr. Lazo-Langner <input type="checkbox"/> Dr. Louzada <input type="checkbox"/> Dr. Mangel	<input type="checkbox"/> Dr. Phua <input type="checkbox"/> Dr. Saini <input type="checkbox"/> Dr. Xenocostas	

Reason for Referral:

Please attach relevant lab results, medication list, and biopsy proven diagnosis