Hematology/Oncology Division
Michael Marte, MD
2421 Silver Stream Lane
Wilmington, NC 28401
Phone: 910-815-7400

PATIENT REFERRAL FORM

REFERRAL FORM MUST BE FILLED OUT COMPLETELY AND FAXED TO 910-341-1900 BEFORE ANY APPOINTMENT CAN BE MADE

Patient Name:_____Sex:_____DOB:_____/_____/_____

SS #:_____-_____-_____Phone#: (H)_____(Work/Cell)_____

Address:_____

Referring MD:_____Phone #:_____Fax #:_____

Address:_____NPI:_____

Insurance Co: Primary:_____Secondary:_____

Authorization Required: Yes No Authorization #:_____Contact #_____

ID #:_____Group #:_____

Subscriber's Name:_____Employers Name:_____

REASON FOR REFERRAL: _____

Urgency of Request: 1st Available:_____1-2 Days:_____1-2 weeks:_____Other (specify):_____

Please fax ALL related medical records including all pertinent office notes, medications, drug allergies, most recent labs, procedures and pathology notes, and insurance cards.

Thank you for allowing Wilmington Health to serve your healthcare needs.

Confirmation: Your patient was contacted and appointment confirmed:
Date:____/____/____Time:_____with _____