## LOMA LINDA UNIVERSITY CHILDREN'S HOSPITAL

# Division of Hematology/Oncology Referral Request

**Loma Linda University Children's Hospital**
**Hematology and Oncology Department**
**Phone: 909-651-1910 | Fax: 909-651-1933**

Thank you for referring your patient to Loma Linda University Children's Hospital Hematology and Oncology department.

## Patient Information

Does the patient live with someone other than the legal guardian? ■ No ☐ Yes, relationship _____

Name _____ DOB _____ Age _____

Parent/guardian _____

Phone number _____ ☐ Cell ☐ Home ☐ Work

Insurance information _____

1. Is this an emergent hematology/oncology referral? ☐ No ☐ Yes
   *If yes, a phone call is required from an MD/NP/RN with clinical information to 909-651-1910, select option one.*
2. Please describe the patient's chief complaint and include onset and laboratory results.

_____

_____

_____

3. What is the key question you would like us to answer?

_____

_____

_____

To expedite appointment scheduling, please provide the following by fax to 909-651-1933:

- ☐ This completed form
- ☐ Medical records related to the chief complaint
- ☐ Prior records including current lab results and a growth chart
- ☐ Authorization

Referring provider name _____ Phone _____ Fax _____

Provider address _____ City _____ ZIP _____

Provider signature _____ Date _____ Time _____

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