Hematology Oncology
Allen Patton, M.D.
Elmer Brestan, M.D.
Alejandro Inclan, M.D.
Thomas Tan, M.D.
Shailesh Patel, M.D.
Thomas Fitzgerald, M.D.
Rami Owera, M.D.

Woodlands North Davis
850.696.4400 phone
850.435.9068 fax
West Florida Office
850.475.2230 phone
850.475.2235 fax
Gulf Breeze Office
850.934.7880 phone
850.916.3610 fax

Urology
Dennis Peters, M.D.
John Garner, M.D.
Frank Greskovich, M.D.
David Bernstein, M.D.
Maurice Bouchard, M.D.
Brett Parra, M.D.
Davinder Sekhon, M.D.

Woodlands North Davis
850.696.4100 phone
850.432.2532 fax
Gulf Breeze Office
850-696-4100 phone
850.432.2532 fax

Radiation Oncology
Joanne Bujnoski, D.O.
Nathan Floyd, D.O.

Woodlands North Davis
850.696.4600 phone
850.912.4506 fax

WOODLANDS™
Medical Specialists

NEW PATIENT REFERRAL FORM

Please complete this form in its entirety (or attach demographics equal to the information required) and fax back with records. If patient is an oncology patient, we will need to have a **pathology report**. If patient is a hematology patient, we will need **labs pertaining to the patient's diagnosis.** Once the completed form is received with records, we will fax this form back to you with an appointment date and time. **We will not be able to make an appointment without records. It is your responsibility to contact the patient with this appointment.**

IF NO RECORDS AVAILABLE PLEASE INDICATE WHY:______________________________

REFERRING DOCTOR: ______________________________ **PHONE:**____________________

CONTACT PERSON & FAX NUMBER____

PATIENT NAME: ____

PATIENT MAILING ADDRESS: ____

____

DATE OF BIRTH: __________________ **SSN:** __________________________________

HOME PHONE: __________________________ **WORK PHONE:** __________________________

INSURANCE CARRIER: ____

AUTHORIZATION NUMBER: ____

REASON FOR REFERRAL: ____

……

To be completed by Woodlands Medical Specialists

DATE APPOINTMENT FAXEDTO REFERRING DOCTOR'S OFFICE:______________________________________

Date of new patient appt.____**Time**______________**am/pm**

Doctor's Name/Location____**Scheduler**____________________________

PLEASE CONTACT PATIENT WITH APPOINTMENT DATE AND TIME.
WE WILL MAIL THE PATIENT AN APPOINTMENT REMINDER CARD, OUR NEW PATIENT PAPERWORK TO BE COMPLETED PRIOR TO HIS/HER VISIT.