Delaware Clinical & Laboratory Physicians, P.A.

Consultation Request

Referral Date: ______________________________

Patient Name: ______________________________

DOB: ________/____________/____________ SSN: ______________________________

Address: ______________________________

____

Primary Phone#: ______________________ Secondary Phone#: ______________________

Insurance: ______________________________

____

Referring Physician: ______________________________

Ref Tel#: ______________________ Fax#: ______________________

PCP: ______________________ Tel#: ______________________

Referral reason: ______________________________

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Please fax to 302-737-5407 along with last office note, 6 months of blood work, and other relevant information for hematology consult. We will contact the patient directly to schedule an appointment.

(Below for DCLP Use only)

Appt Date: ______________________ **Physician:** ______________________

Physician Review: ☐Scheduled appt is OK

☐Routine ☐Next Available ☐Urgent Possible Bone Marrow? ______________
(Yes/No)

Lab orders:

☐ CBC/Diff/Plt ☐Smear ☐(Misc)______________________________

4701 Ogletown Stanton Rd Suite 4200 Newark, DE 19713
Phone – (302) 737-7700 Fax – (302) 737-5407