



REFERRAL FORM

Please check office location

- 2610 Aberdeen Blvd, Gastonia, NC
 - 1212 Spruce Street, Belmont, NC
- Please see our website for details.
www.gastoncancer.com

Patient Information

Name _____ DOB _____

Address _____

City _____ State _____ Zip _____

SSN _____

Insurance Company _____

Reason for Referral _____



Referring Physician Info

Referring Physician _____

Phone # _____ Fax # _____

Person Making Referral _____

Please fax a clear copy of the patient's insurance card(s) along with any records pertaining to the problem.

Please Check Preferred Physician:

<input type="checkbox"/> Steven Yates, MD – Gastonia	<input type="checkbox"/> William Charles, MD - Gastonia
<input type="checkbox"/> Keith Ayrons, MD - Gastonia	<input type="checkbox"/> Vipul Patel, MD - Gastonia
<input type="checkbox"/> Melissa Matulis, MD – Gastonia or Belmont	<input type="checkbox"/> Lia Spina, MD - Gastonia
<input type="checkbox"/> James McGrath, MD - Belmont	<input type="checkbox"/> No Preference

Appointment Type First Available Urgent

Gaston Hematology & Oncology to Complete

Appointment Date _____

Appointment Time _____