



HIGHLAND CLINIC
ONCOLOGY ASSOCIATES

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"Quality Cancer Care Near You"

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HIGHLAND CLINIC HEMATOLOGY/ONCOLOGY REFERRAL FORM

DATE _____ REQUESTED PROVIDER: _____

REFERRING PHYSICIANS NAME _____

PHONE _____ FAX NUMBER _____

NURSE/CONTACT PERSON _____

PATIENT NAME _____ DOB _____

PATIENT ADDRESS _____

SSN _____ PHONE _____

PRIMARY INS _____ POLICY # _____

SECONDARY INS _____ POLICY # _____

**** PLEASE SEND FRONT/BACK COPIES OF INSURANCE CARDS****

SELECT CLINIC LOCATION: SHREVEPORT MINDEN NATCHITOCHE

DIAGNOSIS/ICD10 CODE: _____

PLEASE SEND LAST CLINIC NOTE, MOST RECENT LABS, ANY PATH/XRAYS DX RELATED

NON-CHEMOTHERAPY INFUSIONS REQUESTED:

RITUXAN REMICADE TYSABRI RECLAST IVIG

IRON OTHER: _____

IS THIS AN URGENT REQUEST YES NO

PLEASE FAX REFERRAL REQUEST TO PREFERRED CLINICS FAX NUMBER

NATCHITOCHE: NORTHWEST LA CANCER CENTER
211 MEDICAL DRIVE
NATCHITOCHE, LA 71457
PHONE: 318.238.3322 • FAX: 318.238.3323

MINDEN CANCER CENTER
10600 INDUSTRIAL DRIVE
MINDEN, LA 71055
PHONE: 318.798-4616 • FAX: 318.798-4619

SATELLITE OFFICES:
SPRINGHILL
JONESBORO
HOMER