SURGICAL ONCOLOGY ASSOCIATES OF SOUTH TEXAS

# Referral Information

Please fill in information and fax to (210) 946-1010.

## Physician

Referring Physician_____ Phone _____ Fax_____

Address_____

City_____ State_____ Zip_____

## Patient

Patient Name_____ Home Phone_____ Work/Cell Phone_____

Date of Birth_____ Social Security Number_____

Address_____

City_____ State_____ Zip_____

Insurance Carrier_____ Phone_____

Group #_____ Policy #_____

## Diagnosis

Patient Diagnosis/Concern_____

Short History_____

## Tests

Pathology Test_____ Date/Location of Test_____

Result_____

Please include copies of pathology reports and other test reports from past 90 days._____

## Comments for Dr. Kahlenberg and Staff

**Clinic Manager:**
**Robert Edwards, RN, (210) 946-1400**
**Urgent Referrals – call (210) 748-5096**

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