Virginia Oncology Associates
MSIC
Multispecialty Infusion Clinic

Harbour View
3910 Bridge Rd., Ste. 400 | Suffolk, VA, 23435

Referral Form

Date: _____ /_____ /_____

Drug to be infused: _____

Patient Name: _____

DOB: _____ /_____ /_____ Phone #: _____

Referring Physician: _____

Phone #: _____ Fax #: _____

VOA will contact your patient for an initial consultation. We will obtain insurance authorization for the infused drug(s) and schedule return visits(s) for infusion. We will fax our office visit notes from the consultation and any follow-up visits to the referring physician. We may also require assistance from the referring physician in the event of a denial and need for peer-to-peer.

Patient will require financial assistance: ☐ Yes ☐ No ☐ Unknown

PLEASE FAX THE FOLLOWING INFORMATION WITH THE REFERRAL FORM TO: (757) 466-1128

- ICD-10 Diagnosis code for infused drug: _____
- Written order for the drug, including SIG, signed by referring physician.
- Medical records supporting diagnosis and order for drug.
- Previously tried and failed treatments for diagnosis resulting in new drug order.
- Copy of insurance card(s) front and back
- TOUCH program pre-enrollment form as needed (TYSABRI [natalizumab] only)

(757) 271-0969
Fax: (757) 466-1128
VirginiaCancer.com

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