



**For Immediate Assistance Call: (423) 479-3600**

Please Fax Request to: (423) 303-1234

## Referral Form

PLEASE MAKE AN APPOINTMENT FOR:

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Zip: \_\_\_\_\_

Cell Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Alternate Number (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Insurance: \_\_\_\_\_ Insurance ID: \_\_\_\_\_ Group#: \_\_\_\_\_

Physician Referring Patient: \_\_\_\_\_ NPI: \_\_\_\_\_

Address: \_\_\_\_\_

(Please provide address to mail corresponding medical records for this visit)

Contact Name: \_\_\_\_\_ Secure Direct Email: \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Fax Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Reason for Referral: \_\_\_\_\_

Please Attach:  Demographics  Insurance  Last office Note  Any Studies (MRI,EMG,etc.)

**Please Note:** All records are reviewed at the end of each day. This form will be faxed back to you with an appointment below

**DATE:** \_\_\_\_\_ **TIME:** \_\_\_\_\_

Contact: \_\_\_\_\_

\_\_\_\_ Patient has been contacted by our office and is aware of the appointment.

\_\_\_\_ We were unable to reach the patient by phone. We will attempt to contact your patient three times.

\_\_\_\_ We have left \_\_\_\_ messages on the patients voicemail to call for an appointment.

Thank you for your referral!