

NEW PATIENT REFERRAL FORM

Scheduling Line: 865-331-2060 * Electronic Fax: 865-374-2083



DATE: _____ **Is this referral urgent?** YES NO

Is the patient aware of this referral? YES NO May we contact and notify this patient? YES NO

***Please complete top sections of this form & attach to demographic sheet or complete this entire form, include any relevant clinical documentation, & fax all documents to 865-374-2083. Missing information may result in a processing delay. We will work to coordinate the appointment with your patient.*

Please **SELECT** below how you prefer we notify your office of appointment details:

<input type="checkbox"/>	CERNER MESSAGE ADDRESSED TO:
<input type="checkbox"/>	PHONE: _____ ext: _____ STAFF CONTACT: _____
<input type="checkbox"/>	FAX: _____ ATTN TO: _____

REFERRING FROM:	Referring Provider Name: _____ MD,DO,NP,PA	Group: _____	
	*THIS FORM COMPLETED BY: _____	Specialty: _____	Phone Number for Questions: _____

Referral for: HEMATOLOGY ONCOLOGY GYNECOLOGICAL ONCOLOGY

REFERRING TO:	Reason for Referral: (Diagnosis? ex: cancer of x OR Chronic Anemia) _____
	Preferred TOG Physician or 1st available: _____ <i>Preferred</i> <input type="checkbox"/> Blount <input type="checkbox"/> Harriman <input type="checkbox"/> Oak Ridge <input type="checkbox"/> West <i>Location:</i> <input type="checkbox"/> Downtown <input type="checkbox"/> Lenoir City <input type="checkbox"/> Sevierville

(GynOnc Patients Seen at Blount, Downtown, or West Locations)

PATIENT INFORMATION: (If ATTACHING A DEMOGRAPHIC FORM, ONLY COMPLETE PATIENT NAME BELOW.)

First Name: _____	Middle Name: _____	Last Name: _____	Date of Birth: _____
Primary Phone: Cell? _____	Street Address: _____		SS#: _____
Secondary Phone: Cell? _____	City: _____	State: _____	Zip: _____
			EMAIL: _____

Primary Insurance: _____	ID # _____
Insured Name: _____	Insured Date of Birth: _____
Secondary Insurance: _____	ID # _____
Insured Name: _____	Insured Date of Birth: _____

Interpreter needed? YES NO If yes, Language? _____