Fort Sanders Digestive Disease and Surgery Institute

PROVIDER REFERRAL FORM

Phone: (865) 331- 2715
Fax: (865)331-1034

- Please **fax** the completed form with any pertinent medical records to **(865) 331-1034**
- If this is an **urgent** request outside of our business hours M-F, 8am – 4:30pm please contact the Rapid Access Center (865) 374-0555.

Patient Information

Name (*First, Middle, Last*)	Birth Date (*mm-dd-yyyy*)	Sex (check one) ☐ Male ☐ Female	Preferred Language

Address	City	State	Zip

Home Phone	Cell Phone	Work Phone	Patient email

Insurance Name/Plan	Subscriber Name	Subscriber DOB	ID #	Group #

Appointment Request

Reason for Referral (Symptoms)	
Requested Provider/Specialty	**Diagnosis**

Referring Provider Information

Date / /	Referring Provider Name	Primary Care Provider (optional)

Practice Name	Practice Address

Contact Name	Phone Number	Fax Number	Email

You will receive confirmation once the appointment is scheduled. Thank you for referring your patient to Fort Sanders Digestive Disease and Surgery Institute. For more information, please visit www.