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:

☐	CERNER MESSAGE ADDRESSED TO:		
☐	PHONE:	ext:	STAFF CONTACT:
☐	FAX:		ATTN TO:

REFERRING FROM:

Referring Provider Name: | MD,DO,NP,PA: MD | **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:

Preferred Location: ☐ Blount ☐ Downtown ☐ Harriman ☐ Lenoir City ☐ Morristown ☐ Oak Ridge ☐ Sevierville ☐ West

(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? _____

Reset This Form

V10.20.2021