NEW PATIENT REFERRAL FORM

Thompson Oncology Group
Covenant HEALTH

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	**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? ______________________