TN Vascular

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Referral Form: *Please complete the following & return with applicable records via fax at (615)410-3721.* ***Thank You for your referral!***

Patient Name:_____DOB:_____
Address:_____
Home Phone:_____Cell Phone:_____
Referring Physician:_____ Contact person:_____
Fax Number_____
Reason for referral /visit:_____
Primary Insurance:_____
(Please send copy of card if available)
ID#:_____Group#:_____
Secondary Insurance:_____
ID#:_____Group#:_____
PCP Auth. Req._____Yes _____No
****URGENT_____

Please provide the following:

____Current Office Note

_____ Most Recent Lab Work

_____ Most Recent Diagnostic Imaging Results (C.T., Ultrasound, etc)

____Current medication list

***Dialysis Patients: Days Dialyzed- Mon./Wed./Fri.____ Tue./Thur./Sat.____