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: ____

Phone: ____________________(H)______________________(C)

Referring Physician: ___________________ Contact person: ____________

Fax Number___________________ Phone Number____________________

Reason for referral/visit: ____

All Insurance(s): ______________________________ (Please send copies of card if available) 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 and facility:** ____________________

Mon./Wed./Fri.____ Tue./Thur./Sat.____