

TENNESSEE SURGICAL SPECIALISTS, P.C.

Patient Referrals

Referring Provider: _____ Telephone/Fax Number: _____

APPT DATE _____ APPT TIME _____ **BHE BHW**

Referring office notified (Date/Time/Whom) _____

Patient Notified _____

NAME _____ DOB _____ SS# _____

HOME PHONE _____ CELL/WK _____

Reason _____

DX _____

INS CO _____ ID# _____

Request

- COPY OF INSURANCE CARD*
- Medication List*
- Office, Notes, Labs, Xrays, etc*

URGENCY: Routine _____ 1 week _____ TODAY _____

Special Requests: Location _____ Day of Week _____ Time of Day _____

Provider _____

NOTE: For routine or within 1 week appointments the Office and Patient will be notified after information received and reviewed

DISPOSITION

Made By: _____

Provider: _____

Based on: _____ Dx/Problem _____ Urgency _____ Special Requests

_____ Equitable Distribution