

UT RheumatologY

A Department of the University of Tennessee Medical Center

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* * PLEASE READ ALL OF THE INFORMATION CAREFULLY SO THAT ALL NECESSARY PAPERWORK IS

RECEIVED AND WE CAN GET THE REFERRAL PROCESSED AS QUICKLY AS POSSIBLE. * *

**** REFERRAL WILL NOT BE PROCESSED IF: form isn't completed with demographic sheet, copy of insurance cards, last 3 office notes & any labs or imaging that support the diagnosis. Please also make sure to include current history and physical. Patient email highly desired. ****

** YOU WILL BE CONTACTED BY FAX OR PHONE ONCE APPT IS SCHEDULED ** Referring Physician Information

Date:		Contact Person:			
Referred by:		NPI:			
Address:					
Phone: ()		Fax: ()			
	PATIENT	INFORMATI	<u>ON</u>		
Patient Name:		DOB:	SS#:		
Parent's Name (if patient is unde	er18):				
Address:					
City:	State	::	Zip Code:		
Home #:	Cell #:		Email:		
Primary Diagnosis:					
Primary Insurance:			Referral Needed?		
Secondary Insurance:			Referral Needed?		
Primary Care Physician (if differen	ent from referring Physician):_				
Address:					
Phone:		Fax:			
	UT Rheuma	tology Only			
Pt to see:	Date:		Time:	 	
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