New Patient Rapid Referral Form

Patient Demographics:

Patient Name: _____ DOB: ____ /____ /____ ☐ Male ☐ Female

UT MRN: _____ SSN: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone (H): _____ Cell/Alternate: _____ Email: _____

Insurance Information: (Please include a legible copy of the insurance ID card, front and back)

Primary Insurance: _____ Subscriber: _____ Subscriber DOB: ____ /____ /____

Member ID: _____ Group #: _____

Secondary Insurance: _____ Subscriber: _____ Subscriber DOB: ____ /____ /____

Member ID: _____ Group #: _____

Clinical Information:

Is the patient aware of diagnosis and referral to this office? ☐ Yes ☐ No

Reason for Referral/Diagnosis: _____

Referring Doctor: _____ NPI: _____

Primary Care Physician: _____ ☐ Check if same as Referring Physician

Office Contact: _____ Phone: _____ Fax: _____

Does this patient require an interpreter? ☐ Yes ☐ No If yes, what type/language_____

Are the patient's records available in UTMC's Powerchart? ☐ Yes ☐ No

If no, please provide a history and physical, path reports, lab reports (recent), diagnostic imaging (CT, MRI, PET, x-ray, ultrasound), progress reports and/or operative notes, current medications, problem lists, and a copy of the insurance cards (front and back).

*****University Cancer Specialists Office Use Only*****

Date Recieved: _____ Date Scheduled: _____ Appt. Date: _____

Appt. Time: _____ Assigned Provider: _____ ☐ Office Notified ☐ Patient Notified

Fax form to referral source as confirmation of appointment

Date: _____ Fax Confirmation Received ☐ Yes ☐ No Schedular Initials:_____

Downtown Fax: 865-305-8199
Lenoir City Fax: 865-458-3928
Alcoa Fax: 865-977-6018

UT MEDICAL CENTER
CANCER INSTITUTE

Sevierville Fax: 865-428-3734
Maryville Fax: 865-984-8279
Halls Fax: 865-925-9076