

UNIVERSITY INFECTIOUS DISEASES CLINIC  
1932 ALCOA HIGHWAY C-580

DATE REFERRAL RECEIVED: \_\_/\_\_/\_\_

**University Infectious Disease Clinic**

**New Patient Referral Form**

Phone: 865-305-6175 Fax: 865-305-3488

Referring office please include the following to ensure your patient is scheduled in a timely manner.

**\*\*Copies of insurance cards, Medication list, MOST RECENT office notes, Lab and/or diagnostic testing pertaining ONLY to the DX of the patient. IF THESE documents are not submitting the referral may not be accepted OR could delay the scheduling process. \*\***

**Referring Physician**

Date: \_\_\_\_\_ Office Contact: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Fax: \_\_\_\_\_ Patient's PCP \_\_\_\_\_

**Patient Information**

Patient Name: First: \_\_\_\_\_ M/I \_\_\_\_\_ Last: \_\_\_\_\_ DOB \_\_/\_\_/\_\_

SS Number \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Email: \_\_\_\_\_ Phone: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

PRIMARY INSURANCE: \_\_\_\_\_ Secondary Insurance \_\_\_\_\_

Referral Needed? Yes / No Does the patient need an interpreter (Spanish, ASL, French... etc..)? Yes / No

REASON FOR CONSULT: \_\_\_\_\_ **NO DIAGNOSIS CODES ACCEPTED**

IF you are referring a patient for Hep C, please ensure all the labs are done on the 2<sup>nd</sup> page of this referral and faxed to our office with the referral.

We do not treat/manage HIV patients, you may send them to the Knox County Health Department.

IF you are referring a patient for Latent TB, please ensure there is an UP-TO-DATE CXR that is attached to the referral.

APPOINTMENT DATE: \_\_\_\_\_ TIME: \_\_\_\_\_ AM/PM

PROVIDER: SHORMAN VINCENT SINGH WALKER WANG FAXED: \_\_\_\_/\_\_\_\_/\_\_\_\_

**\*\*Please inform your patient of their appointment time/date. Please tell the patient to bring their insurance card, ID, Pharmacy Card and a medication list with them to their appointment. Your patient is notified by mail of this appointment with a new patient packet they are asked to fill out and bring with them completed to the appointment. If the patient does not receive the packet, they can come 10-15 min early to fill it out. IF the patient is more than 15 min late, we will ask them to reschedule their appointment. Please feel free to send any other documentation leading up to their appointment that would be beneficial to the visit to 865-305-3488 ATTN: HALEY.**

THANK YOU FOR YOUR REFERRAL, WE APPRECIATE YOU!

## University Infectious Diseases Clinic

**\*This sheet is beneficial only for *hepatitis C* and *hepatitis B* referrals\***

### **\*\*Pertinent labs for *POSITIVE HEPATITIS C* referrals\*\***

1. HCV Genotype
2. HCV PCR Quantitative
3. Fibrotest (fibrosure)
4. HBV Surface Antigen
5. HBV Surface Antibody
6. HBV PCR Quantitative
7. HAV IgG
8. CBC
9. BMP
10. Liver Function Test
11. HIV testing

### **\*\*Pertinent labs for *POSITIVE Hepatitis B* Referrals\*\***

1. HBVe Antigen
2. HBVe Antibody
3. HBV PCR Quantitative

**Please understand the patient cannot be scheduled till proper testing has been done to give your patient optimal care when they come in for their visit with us.**