1915 White Ave.
Knoxville, TN 37916
865.331.1720
Fax: 865.331.2640

9711 Sherrill Blvd.
Knoxville, TN 37932
865.373.5050
Fax: 865.373.5051

576 Ft. Loudoun Med. Ctr. Dr.
Lenoir City, TN 37772
865.271.6095
Fax: 865.271.6096

220 BMH Cancer Ctr.
Maryville, TN 37804
865.977.1065
Fax: 865.982.8538

908 W. 4th North St.
Morristown, TN 37814
423.492.6100
Fax: 423.492.6101

200 New York Ave.
Suite 200
Oak Ridge, TN 37830
865.835.5400
Fax: 865.835.5401

8035 Roane Medical Center Dr.
Suite 230
Harriman, TN 37748
865.835.5400
Fax: 865.835.5401

710 Middle Creek Rd.
Sevierville, TN 37862
865.446.9025
Fax: 865.446.9078

www.thompsoncancer.com

THOMPSON ONCOLOGY GROUP

December 1, 2020

Dear Provider Partner,

Thank you for trusting Thompson Oncology Group with the care of your patients. We value the relationships we have with our referring providers and their teams. We know how busy healthcare offices are and we want to be the best and easiest choice for your referrals.

We frequently evaluate how we can improve and ensure a seamless continuation of patient care from your office to ours. As a result, we updated some of our forms to improve communication.

Please use our new *Patient Referral Form* to facilitate accurate and efficient scheduling of your patients. We have attached one for your convenience and it will be available for download on our website. If you plan to attach a patient demographic sheet, you do not need to duplicate the information in the bottom section. Our goal is to complete your request and schedule your patient as quickly as possible. This form will help us accomplish that goal.

We always welcome and appreciate your feedback or suggestions for improvement.

Thank you,

Jenni Turner, MBA
Director Business Development
Thompson Cancer Survival Center /
Thompson Oncology Group /
Covenant Health
jturne15@covhlth.com
o: (865) 331-1957
c: (865) 850-0889

NEW PATIENT REFERRAL FORM

Scheduling Line: 865-331-2060

Electronic Fax: 865-374-2083

DATE: / / **Is this referral urgent?** YES ☐ NO ☐

Is the patient aware of this referral? YES ☐ NO ☐

Is the patient expecting a call? YES ☐ NO ☐

May we contact and notify this patient? YES ☐ NO ☐

Referral for: ☐ HEMATOLOGY ☐ ONCOLOGY ☐ GYNECOLOGICAL ONCOLOGY

***Please complete top sections of this form & attach to demographic sheet or complete this entire form, include any relevant clinical documentation, & fax all documents to 865-374-2083. Missing information may result in a processing delay. We will work to coordinate the appointment with your patient.*

Please SELECT below how you prefer we notify your office of appointment details:

☐ CERNER MESSAGE ADDRESSED TO:

☐ PHONE: ( ) - ext: STAFF CONTACT:

☐ FAX: ( ) - ATTN TO:

REFERRING FROM:

Referring Provider Name: | MD,DO,NP,PA | Group:

*****THIS FORM COMPLETED BY:** | Specialty: | Number for Questions: ( ) -

REFERRING TO:

Reason for Referral: | **Diagnosis (Wording):** | ICD 10:

Preferred Physician or 1st available:

Preferred Location: ☐ Blount ☐ Harriman ☐ Oak Ridge ☐ West ☐ Downtown ☐ Lenoir City ☐ Sevierville

(GynOnc Patients Seen at Blount, Downtown, or West Locations)

PATIENT INFORMATION: *(IF ATTACHING A DEMOGRAPHIC FORM, ONLY COMPLETE PATIENT NAME BELOW.)*

First Name: | Middle Name: | Last Name:

Primary Phone: ( ) - | Secondary Phone: ( ) - | Gender: | Date of Birth: / / | SS#: - -

Street Address: | City:

State: | Zip: | Interpreter Needed? | Language if non-English language:

Primary Insurance: | ID# | Group#

Insured Name: | Insured Date of Birth: / /

Secondary Insurance: | ID# | Group#

Insured Name: | Insured Date of Birth: / /