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Harriman, TN 37748
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Sevierville, TN 37862
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www.thompsoncancer.com

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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.

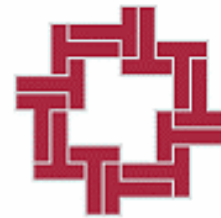
Thank you,

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

Scheduling Line: 865-331-2060

Electronic Fax: 865-374-2083



**THOMPSON
ONCOLOGY
GROUP**

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 Blount Harriman Oak Ridge West
Location: 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: / / _____