# NEW PATIENT REFERRAL FORM

Scheduling Line: 865-331-2060 ✳ Electronic Fax: 865-374-2083

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

**Referral for**: ☐ **HEMATOLOGY** ☐ **ONCOLOGY** ☐ **GYNECOLOGICAL ONCOLOGY**

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

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

THOMPSON ONCOLOGY GROUP

***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: / /