Reg Cx Cntr and MSMG use Provider Referral Forms

2019 HOSPITAL Referral Request Form

423.232.6700 (P)
423.232.6707 (F)

www.ProjectAccessEastTn.org

Part A: Person Submitting Referral

Name: _____ From Dept: ☐Pt Fin Accts ☐ER ☐Soc Wrk

From Facility: ☐JCMC ☐FWCH Phone:_____ Fax:_____

Email: _____ Preferred method of Contact: ___Ph ___Fx ___Email

Part B: Patient Demographics

Preferred Language:_____

Patient Name: _____ Sex: ____Male ____Female

Patient's Social Security #: _____-_____-_____ Age:_____ Date of Birth: _____/_____/_____

Phone (Home #): _____ (Mobile #): _____ (Other #): _____

Address:_____

City: _____ State: TN_ County:_____ Zip: _____

Part C: Screening Information

Reason for Referral? (Ex: Hospitalization, Diagnostic, etc.)_____

Chief Complaint/Admitting Diagnosis: _____

Date of Admission _____ Date of Discharge _____

Has the Patient APPLIED for Patient Financial Assistance within the last 6 months? ☐ Yes ☐ No

Has the Patient been APPROVED within the last 6 months? ☐ Yes ☐ No

Has the Patient been provided information about the Project Access program? ☐ Yes ☐ No

Part D: Medical Information

Who is the Patient's Primary Care Provider? _____ ☐Don't Know ☐Doesn't Have

Does the Patient need a Referral to a Specialist? ☐ Yes ☐ No

If yes, which Specialty Area(s)? _____

Does the patient need follow-up Diagnostics/Procedures? ☐ Yes ☐ No

If yes, what Diagnostics/Procedures _____

Are there medical notes, orders, discharge instructions or any other documentation available and attached to this referral?
☐ Yes ☐ No

Authorized Signature: _____ **Date**: _____/_____/_____