2019 Referral Request Form

423.232.6700 (P)
423.232.6707 (F)

www.ProjectAccessEastTn.com

Part A: Provider Requesting Referral

Provider: _____ Specialty: _____

Office Name: _____ Phone: _____

Contact Person: _____ Fax:_____

Preferred Contact Method: ____Phone ____ Fax ____Email Email Address: _____

Part B: Patient Demographics Preferred Language: _____

Patient Name: _____ Male_____ Female _____

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

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

Address: _____

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

***Date the patient was first seen in your office: _____**

***Requests must be accompanied by supportive documentation. Please send any Medical Records, Office Notes, and/or relevant Diagnostics/Lab Results for the specific Diagnostics and/or Specialty areas requested below.**

Part C: Diagnostic Procedure Requested

Level of Urgency: _____ STAT (Urgent) _____ ASAP (Moderate) _____ Basic

Diagnosis: 1. _____ 2. _____ 3. _____

ICD 10: 1. _____ 2. _____ 3. _____

Diagnostic Procedure/Exam Requested: _____w/ contrast _____w/o contrast _____ w/ & w/o contrast

1. _____ 2. _____

3. _____ 4. _____

Part D: Specialty Requested

Level of Urgency: _____ASAP (Priority Attention) _____When Possible _____As Result of Labs/Diagnostics

Specialty Area(s) Requested (please do not list a specific provider):

_____

Incomplete referrals cannot be processed.
All referrals will be processed in the order in which they were received unless circumstances dictate otherwise.
Project Access patients can be referred to only those providers who participate with Project Access.
Our office MUST schedule diagnostics and initial specialty care consults in order to monitor participation levels, ensure the rotation of providers, and utilize our case management services most effectively.

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