2020 Referral Request Form

423.232.6700 (P)
423.232.6707 (F)

www.ProjectAccessEastTn.org

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: ______________

***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: Medical Need

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. ______________________________

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**: _____/_____/_____