EAST TENNESSEE Children's Hospital

East Tennessee Pediatric Surgery Group

2100 Clinch Avenue, MOB, Suite 430
Knoxville, TN 37916

Phone: 865.546.2131 Fax: 877.821.0891

Referral Request

Referral Reason: ☐ New Patient Visit/Consultation ☐ Return Consultation

Referring Physician: _____

Address: _____

City: _____ St: _____ Zip: _____

Phone: _____ Fax: _____

Patient Name: _____ DOB: _____

Address: _____

City: _____ St: _____ Zip: _____

SS# _____ Parent/Guardian: _____

Phone: _____ 2nd Phone: _____

Insurance Primary: _____

Insurance Secondary: _____

******Please send a copy of the insurance card if available******

Reason for Referral: _____

Relevant History: _____

Does this patient require an interpreter? ☐ Yes ☐ No

Please fax all relevant clinical documents including radiology and labs with this form.

New patients must be accompanied by a parent or legal guardian.

*****Office Use Only***** Appointment: _____

Appointment will be scheduled with the **ON CALL SURGEON: Dr. Angel; Dr. Vaughan; Dr. Jensen; Christie Curry, PA-C**

Appointment not scheduled (reason): _____

Records Received from Primary Care: _____