EAST TENNESSEE Children's Hospital

Pediatric Gastroenterology

2100 Clinch Avenue, MOB 420
Knoxville, TN 37916
Phone: (865) 824-0083
Fax: (865) 246-7565

Referral Request

Please fax the following information with this completed referral form:

- Last office visit record
- Insurance cards (front and back)
- Guardianship papers
- Relevant lab work and test results

Referring Provider: _____ Date: _____

Office Phone: _____ Office Contact: _____

Reason for referral: _____

_____

Demographics

Patient Name: _____ Date of birth (DOB): _____

Address: _____

_____

City: _____ State: _____ Zip: _____

SS# _____

_____

Parent/Legal Guardian: _____

Phone: _____ Email: _____

Does this patient require an interpreter? Yes No Language: _____

Insurance Information

Primary Insurance: _____

Policy Holder's Name: _____ Policy Holder's DOB: _____

Secondary Insurance: _____

Policy Holder's Name: _____ Policy Holder's DOB: _____

Office Use Only

Appointment Date: _____ Provider: _____

Appointment not scheduled? Reason? _____

_____

Records received from primary care: _____