EAST TENNESSEE Children's Hospital

Pediatric Neurology
2100 W Clinch Ave, Suite 210
Knoxville, TN 37916
p. (865) 523-5437 f. (865) 246-7566

Patient Consultation Request Form

Fax **COMPLETED** form, medical records, and insurance card(s) (front and back) to East Tennessee Children's Hospital Pediatric Neurology. For questions, please call our office. Allow up to **3** business days for scheduling.

PART I - REFERRING PHYSICIAN INFORMATION

Today's Date: _____ Practice Name: _____

Referring Physician: _____ NPI#: _____

Address: _____ City: _____ State: _____ Zip: _____

Contact: _____ Phone: _____ Fax: _____

PART II - PATIENT INFORMATION

Patient Name: _____ DOB: _____ SSN: _____
(First, Middle Initial, Last) **(required for TennCare patients)**

Gender: ☐ M ☐ F Interpreter Needed? ☐ Y ☐ N Specify Language: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Phone: _____ Secondary Phone: _____

Insurance(s): _____ (PRIMARY) _____ (SECONDARY)

Is this child in foster care? ☐ Y ☐ N Case Manager Name: _____ Phone: _____

PART III - GUARANTOR INFORMATION (If not a parent, we will need court documents pertaining to placement)

Guarantor Name: _____ Relationship to Patient: _____

DOB: _____ SSN: _____

PART IV - APPOINTMENT INFORMATION

Presenting Diagnosis/Problem: _____

Please circle specific provider or first available for scheduling:

Karsten Gammeltoft, M.D. Namita Garg, M.D. Anna Kosentka, M.D. Jessica Sheah, M.D.

Bilge Nur Yesiltepe, M.D. Amy Long, P.A. First Available

Additional Comments: _____

WE MUST RECEIVE A COMPLETED CONSULTATION REQUEST FORM, MEDICAL RECORDS, AND A COPY OF THE INSURANCE CARD (FRONT AND BACK) BEFORE AN APPOINTMENT WILL BE SCHEDULED. Once we receive everything, we will call the guarantor to schedule an appointment. We will then fax the form, with the appointment information, back to your office for your records. PLEASE NOTE: WE WILL MAKE 3 ATTEMPTS TO REACH THE GUARANTOR TO SCHEDULE YOUR PATIENT AN APPOINTMENT.

FOR OFFICE USE ONLY - DO NOT WRITE BELOW THIS SECTION

Appointment Date: _____ Arrival Time: _____

Physician: _____ Scheduled With: _____

Call Attempts: _____ Informed Referring Office: _____