EAST TENNESSEE Children's Hospital

Pediatric Infectious Disease

2018 Clinch Avenue
Knoxville, TN 37916

p: (865) 541-8709
f: (865) 541-8207

New Patient Referral

Complete top portion of this form then fax form along with the following information to (865) 541-8207

☐ Pertinent office/progress notes ☐ Lab/blood work ☐ Radiology/imaging reports ☐ Insurance Card (s)

PATIENT INFORMATION (please print clearly)

Last name: _____ First name:_____ Initial_____

Address: _____ City: _____ State: _____ ZIP: _____

☐ Male ☐ Female Date of Birth: ____/_____/_____ Interpreter ☐ Yes-Language: _____

Parents/Guardian name: _____ Relationship to patient: _____

Parents/Guardian DOB: ____/_____/_____ Home: (_____) _____ Cell: (_____) _____

PROVIDER INFORMATION

Referring provider: _____ Contact person: _____

Phone: _____ Fax: _____ PCP: _____

REFERRAL INFORMATION

Specific ID issue _____

_____

Relevant Medical History _____

Priority: ☐ approximately 4-6 weeks ☐ approximately 2-3 weeks ☐ Next available ☐ Other_____

Provider should call (865) 541-8709 if urgent/emergent to discuss patient with a ID provider

If referring for fever/fatigue we must have at least a two week fever log faxed with referral before appointment is scheduled.

Please include: Immunizations records, growth chart, any and all labs or cultures pertaining to referral/and or office notes. These things will speed up the process of the appointment.

_____

FOR ETCH Infectious Disease OFFICE USE ONLY

Date/Time: _____ ☐ Cancel ☐ Reschedule ☐ No Show - reason: _____

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