# New Patient Referral

Hematology & Oncology

Dolly Parton CHILDREN'S HOSPITAL

Complete top portion of this form then fax form along with the following information to 865-541-8553

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

**PATIENT INFORMATION (please print clearly)**

Last name: _____ First name:_____ Intial: _____

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 Hem/Onc Issue: _____

_____

Relevant Medical History:_____

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

**Provider should call (865) 541-8266 if urgent/emergent to discuss patient with a Hem/Onc provider**

FOR ETCH HEM/ONC OFFICE USE ONLY

Date/Time:_____ ☐ cancel ☐ reschedule ☐ no show-reason: _____

Date/Time:_____ ☐ cancel ☐ reschedule ☐ no show-reason: _____

Date/Time:_____ ☐ cancel ☐ reschedule ☐ no show-reason:_____

*After 3rd cancellation/reschedule/noshow, patient must be re-referred after repeat evaluation by referring provider.*

☐ Shelly ☐ Meditech Mailed map: _____

☐ Corns ☐ Hamm ☐ Kacvinsky ☐ Mackey ☐ Brodwater ☐ Melnikov ☐ Spiller

Notes

_____

_____

_____

_____

_____

_____