



2018 Clinch Avenue  
South Tower, 2nd Floor  
Knoxville, TN 37916

Phone: (865) 522-0420  
Fax: (865) 246-7564

**Pediatric Cardiology**

**Fetal Referral Request**

**\*We will not schedule the appointment unless this form is completed in full**

**Please fax the following information with this completed referral form to (865) 246-7564:**

- Last office visit record
- Demographics
- Insurance cards (front and back)
- Last Ultrasound
- Relevant lab work
- Genetic Testing
- **Any previous cardiac records (Op notes, ekg, echo, heart monitor results, cath reports, stress test etc.)**

Referring Provider: \_\_\_\_\_ Date: \_\_\_\_\_

Office Phone: \_\_\_\_\_ Office Contact: \_\_\_\_\_

Office Fax: \_\_\_\_\_ New or Returning patient: \_\_\_\_\_

Gestation: \_\_\_\_\_ Mother's Name: \_\_\_\_\_ Maiden Name: \_\_\_\_\_

Previous Fetal Patient:  Yes  No If previously seen by Cardiology for a fetal, when and where were you last seen? \_\_\_\_\_

Sibling seen by a Provider here?  Yes  No If yes, please provide the sibling's name, DOB, and heart defect: \_\_\_\_\_

Reason for referral (BE SPECIFIC): \_\_\_\_\_

**Provider preference? (Please check one)**

- First Available  Dr. Yvonne Bremer  Dr. David Hurst  Dr. Michael Liske  Dr. Sumeet Sharma

**Demographics**

Patient Name: \_\_\_\_\_ Date of birth (DOB): \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

SS# \_\_\_\_\_

Does this patient require an interpreter? If so, what language?  Yes \_\_\_\_\_  No

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

**Insurance Information**

Primary Insurance: \_\_\_\_\_

Subscriber ID: \_\_\_\_\_ Group #: \_\_\_\_\_

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: \_\_\_\_\_