

EAST TN CHILDREN'S HOSPITAL GENETICS CENTER
SPECIALIST REFERRAL REQUEST
PHONE 865.525.1425 FAX 877.935.4221

Patients Name: _____ DOB: _____ Age: _____

(First) (Middle) (Last)
Gender: M F Social Security Number: _____ Insurance: _____

Mailing Address: _____
(Street & PO Box) (City) (State) (Zip)

Patient resides with: _____ Home Phone: (_____) _____

*******GUARDIANS MUST BRING PROOF OF GUARDIANSHIP TO THE APPOINTMENT*******

Mother's Name: _____ Mother's SSN: _____ DOB: _____

Mother's Cell Phone: (_____) _____ Work Number: _____ Email: _____

Father's Name: _____ Father's SSN: _____ DOB: _____

Father's Cell Phone: (_____) _____ Work Number: _____ Email: _____

Referring Healthcare Provider: _____ NPI: _____ Office Contact: _____

Office Phone: (_____) _____ Office Fax: (_____) _____

Date of request: _____ Primary Care Provider (if other than referring): _____

***TO BE COMPLETED BY REFERRING PROVIDER.**

REASON FOR REFERRAL

- | | |
|--|--|
| <input type="checkbox"/> Developmental disorder | <input type="checkbox"/> Syndromic findings |
| <input type="checkbox"/> Multiple congenital anomalies | Specify _____ |
| <input type="checkbox"/> Neurologic disease | <input type="checkbox"/> Family history of confirmed genetic disease |
| <input type="checkbox"/> Inborn error of metabolism | Specify _____ |
| <input type="checkbox"/> Abnormal genetic test results (MUST BE ATTACHED) | <input type="checkbox"/> Hearing loss |

Please fax the following with this completed form:

- Insurance card (Front and back with carrier's DOB and SSN)
- Most recent provider note explaining reason for referral
- Genetic test results for patient and/or family members, if applicable.
- Growth Chart

NUMBER OF PAGES BEING FAXED: _____ **LEGAL GARDIAN'S RELATIONSHIP:** _____

Please rate urgency of your referral: **Routine** **Semi-Urgent** **Urgent** **Reason** _____

Is this the first referral to Genetics at ETCH? YES NO

Is an Interpreter needed for Hearing Impairment or Language? NO YES, Language: _____

Is the parent/guardian aware the patient needs a consultation with this provider and do they understand the reason for this consult: YES NO if no, list the reason _____

YOUR PATIENT HAS BEEN SCHEDULED FOR THE FOLLOWING:

DATE _____ TIME _____

PROVIDER: J. AUSTIN HAMM, MD SARA NORTON, PNP PC ESTHER O'HARE, FNP BC
ABBEY JAMISON, GC MEGAN KEENEY, GC

LOCATION: Scripps Tower, 2nd Floor for GPS: 700 21st Knoxville, TN 37916 Parking Garage B

SPECIAL INSTRUCTIONS: **Please notify the family of above appointment. Thanks.**

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