



Pediatric Physiatry
2100 Clinch Avenue, Suite 210
Knoxville, TN 37916
Office: 865-523-5437
Fax: 865-246-7569

Physiatry Referral Request

Please send the following information along with the referral form

- Completed referral form
Physician's last office visit
Demographics
Insurance cards (copy front and back)
Insurance authorization (if required)
Medication list
Pertinent test results
Guardianship papers

Has this patient been seen by another Physiatrist? Yes No

If yes: Physiatrist name: Date last seen:

Referring physician: Date:
Office phone: Contact person:
Patient's name: Date of Birth:
Patient's SSN: Gender: Male Female
Language preferred:
Address: Hearing impaired Yes No
City: Zip Code:
Primary insurance:
Secondary insurance:

\*\*\*Guardian must bring proof of guardianship to the appointment\*\*\*

Mother/guardian's name: Home phone:
Mother/guardian's SSN:
Cell phone: Work phone:
Father/guardian's name: Home phone:
Father/guardian's SSN:
Cell phone: Work phone:

Reason for referral (please mark all that apply)

- Acquired brain injury
Cerebrovascular accident
Gait abnormalities
Prematurity
Spinal cord injury
Amputation
Cerebral Palsy
Muscular Dystrophy
Multiple Sclerosis
Peripheral nerve injury
Spasticity
Spina Bifida
Torticollis
Wheelchair equipment management
Neuromuscular disease
arthrogryposis
Other: