USA
UNIVERSITY SURGICAL ASSOCIATES
Exceptional surgeons. Compassionate care.

USA VASCULAR SURGERY

Patient Referral Form

Phone: 423-267-0466 Fax: 423-778-5177 universitysurgical.com

Date: _____ Referring Physician Name: _____

Office Contact: _____ Phone: _____ Fax: _____

Email Address: _____

USA Physician Requested: _____

Patient Name: _____

Patient Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Date of Birth: _____ Male Female SSN: _____

Insurance: _____

Group # _____ Subscriber ID # _____

Diagnosis, Tests and/or Symptoms: _____

_____

Day/Time Patient is Available for Appointments: M T W Th F Mornings Afternoons

USA Office Preferred: _____

******Along with this form, please fax demographics, office notes, tests, studies, ultrasounds, lab results, and legible copy of insurance cards.***

FAX TO: 423-778-5177


Ehsan Benrashid, MD, RPVI


Michael S. Greer, MD, FACS, RPVI


Neelima Katragunta, MD, FACS


Charles S. Joels, MD, FACS, RPVI

Thank you for your referral!

USA will contact the patient with the appointment information.