



# Patient Referral Form

Phone: 423-267-0466 Fax: 423-778-5177 [universitysurgical.com](http://universitysurgical.com)

\_\_\_\_\_ Urgent      \_\_\_\_\_ STAT      \_\_\_\_\_ Routine

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

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

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

USA Physician Requested: \_\_\_\_\_

Patient Name: \_\_\_\_\_

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

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

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Male Female SSN: \_\_\_\_\_

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

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

Subscriber Name: \_\_\_\_\_ Subscriber DOB: \_\_\_\_\_

Diagnosis, Tests and/or Symptoms (include ICD 10 code): \_\_\_\_\_

If any related imaging was performed, please provide the name of the facility: \_\_\_\_\_

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

IF FOR CHEMO PORT PLACEMENTS, treatment start date: \_\_\_\_\_

IF PATIENT IS A MINOR, guarantor name and DOB: \_\_\_\_\_

USA Office Preferred: \_\_\_\_\_

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

## **FAX TO: 423-778-5177**

***Thank you for your referral!***

***USA will contact the patient with the appointment information.***