Telephone: 865-630-9205 FAX: 865-630-9203

Referral Form

Patient's Name____________________________DOB _______ Age______

Primary Diagnosis____

Insurance Information

Company Name_______________________

ID number___________________________

(Please attach a copy of face sheet/demographic sheet, and photo ID if available)

COVID Vaccines: YES________ NO___________

If yes please provide the dates of each vaccine

1st COVID Vaccine ________

2nd COVID Vaccine ________

COVID Booster ________

Dates of last Flu vaccine:____________ Pneumonia Vaccine:____________

Things We Require	**Results Attached**
Chest X-ray (To rule out TB and Pneumonia)	YES___ NO____
Urinalysis (To rule out UTI)	YES___ NO____
CBC and BMP	YES___ NO____
Current Medication List	YES___ NO____