CENTRAL TENNESSEE
EAR, NOSE & THROAT

Referral Form

Referring Provider:

Name: ____________________

Phone: ____________________

Fax: ____________________

Patient Information:

Name: ____________________

DOB: ____________________

Address: ____________________

____

Phone: ____________________

Primary Insurance: ____________________

Policy Number: ____________________ Group Number: ____________________

Secondary Insurance: ____________________

Policy Number: ____________________ Group Number: ____________________

Reason for Referral:

Diagnosis: ____________________

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Diagnosis Code(s): ____________________

Please fax the referral form along with copies of insurance cards, last office note, and any imaging or tests results related to the diagnosis to (931)647-2399.