TENNESSEE SPINE SPECIALISTS

REFERRAL FORM

EMAIL TO: scheduling@tnspinespecialists.com

Patient Name _____ **Referral Date** _____

Gender: M F **Phone** _____ **Date of Birth** _____ **Date of Injury** _____

Address _____ **City** _____ **State** ____ **Zip** _____

Insurance Company _____ **ID/Claim** _____

Attorney _____ **Phone** _____ **Fax** _____

BRING ALL IMAGING DISCS & REPORTS TO APPOINTMENT

REGION

- ☐ Lumbar
- ☐ Thoracic
- ☐ Cervical
- ☐ Knee (R / L)
- ☐ Shoulder (R / L)
- ☐ Other: _____

Prior Treatment _____

Diagnostic Testing: MRI CT X-RAY _____

Facility _____ **Date of Service** _____ **Phone** _____

Special Instructions _____

Referring Physician _____ **Phone** _____ **Fax** _____

Physician Signature _____ **Date** _____

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Toll Free: 855-4TNSPINE 855-486-7746 Local: 865-424-2007