Project Access
West Tennessee

# Request for Referral

Referral Date: _____ Referring Clinic: _____

Referring Provider: _____

Clinic Address: _____

Direct Phone Number: _____ Fax Number: _____

## Patient Information

Name: _____ DOB: _____

Address: _____ Zip Code: _____

Primary Phone: _____ Alternate Phone: _____

Primary Language: _____ Speaks English? ☐ Yes ☐ No

SSN (N/A if patient does not have one): _____

Patient is Available (please circle): Mon Tues Wed Thurs Fri ☐ Mornings ☐ Afternoons

*Type of Specialist Needed*

| | | | |
|---|---|---|---|
| ☐ Breast Surgery | ☐ Gastroenterology | ☐ Nephrology | ☐ Plastic / Reconstructive Surgery |
| ☐ Cardiology | ☐ General Surgery | ☐ Neurosurgery | ☐ Pulmonology |
| ☐ Cardiovascular Surgery | ☐ Gynecology | ☐ Oncology | ☐ Radiation Oncology |
| ☐ Dermatology | ☐ GYN/Oncology | ☐ Ophthalmology | |
| ☐ Endocrinology | ☐ Hematology | ☐ Outpatient Rehab: _____ | |

Please attach office notes with any demographics, labs, and imaging reports to every referral.

Diagnosis/Reason for Referral: _____

_____

Have you attached a copy of financial/ income information for the patient to verify need? ☐ Yes ☐ No
If this is not available, PAWT will contact the patient to coordinate proof of income submission which must be received before scheduling.

*For **PAWT** Specialty Care Office use only*

| | |
|---|---|
| MD: | ON/FN: |
| Date: | Time: |

**Project Access West Tennessee**
**1067 Cresthaven Rd• Memphis**, TN **38119 • 901-761-0200** • Fax
**901-374-9574**

**Click here to submit this form!**