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

☐ Urology	☐ Gastroenterology	☐ Neurology	☐ Physical Medicine
☐ Cardiology	☐ General Surgery	☐ Oncology	☐ Pulmonology
☐ Cardiovascular Surgery	☐ Gynecology	☐ Pain Med	☐ Allergy/Immunology
☐ Dermatology	☐ GYN/Oncology	☐ Ophthalmology	
☐ Endocrinology	☐ Nephrology	☐ Orthopedics _____	

Please attach **most recent** 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 **901-339-1276**

Click here to submit this form!