For assistance call: 615-227-3000, ext. 1750

Referral Request Form

(Items with ** are required for processing)

Priority: **Routine** ☐ **Urgent** ☐ ☐ **If uninsured, applied for CoverRx at** _____

Patient Information	Reason for Referral
Name (First, Middle, Last)**	**If urgent, please describe****
Date of Birth (Day. Month, Year)**	**Diagnosis/ICD 10 (if applicable)**
Address**	**Service Requested**** Establish PCP ☐ Adult Well Visit ☐ Emergency Dept. F/U ☐ IOP ☐ MAT ☐ **OBGYN:** New OB ☐ Birth Control Consult ☐ Well Woman Exam ☐ Colposcopy ☐ Other ☐ **Dental:** Comp. Exam ☐ Adult ☐ Peds ☐ **Pediatric:** Well Child Check ☐ Immunizations ☐ Other ☐ **Describe Other:** _____
City, State, Zip Code**	
Phone Number**	
Interpreter Needed? ** Yes ☐ **No** ☐ **Preferred Language** ☐ Spanish ☐ Arabic ☐ Kurdish ☐ Other: _____	

Referring Provider Information	
Practice Name/Specialty** _____	**Phone Number**** _____
Address** _____	**Fax Number**** _____
City, State, Zip Code** _____	**Contact Person**** _____

Referral Checklist (include with submission)

☐ **Patient Demographic Sheet** ☐ **Copy of Photo ID** ☐ **Proof of Income (30 days)**
☐ **Copy of Insurance card (if applicable)** ☐ **All relevant clinical notes**

Appointment information (For Office Use Only)	Choose from the clinic locations below, or leave blank	
Date: _____ **Time:** _____ **Location:** _____ **Provider:** _____	☐Casa Azafrán 2195 Nolensville Pike ☐Cayce Place 617 South 8th Street ☐Cleveland Park 1223 Dickerson Pike ☐Downtown Clinic 526 8th Avenue South ☐East Side 905 Main Street ☐Inglewood 3904 Gallatin Pike	☐Lebanon 217 E. High St., Suite 200 ☐Madison 601 W. Due West Ave. ☐Napier Place 107 Charles E. Davis Blvd. ☐Salvus Clinic 556 Hartsville Pike, #200 ☐Welshwood 419 Welshwood Drive

Please send this form with all pertinent clinical records attached to: refer@nhtn.org or fax to (615) 523-1306