Fax

|  |  |
| --- | --- |
| Date: |  |
| To: |  | From: |  **Referrals Department** |
| Fax: |  | Fax: |  **615-341-4498** |
| Phone: |  | Phone: |  **615-341-4720** |
|  | Re: |  |
| # of Pages (including cover): |  |

[ ]  Urgent [ ]  For Review [ ]  Please Comment [ ]  Please Reply [ ]  Please Recycle

⚫ Comments: Schedule appointment according to the providers discretion unless otherwise noted.

Please Fax Referrals Department the following information:

* Patient’s appointment date and time
* Consults or progress reports after patient visit

NHC’s requests the following information to effectively coordinate care for every patient:

|  |  |
| --- | --- |
| * Medical summary
* Progress notes, EKGs, labs, imaging, specialty forms and other patient documents relevant to the referrals
* Reason for referral
* Type of referral
 | * Urgency
* ICD-10 diagnosis codes
* Patient demographic information (e.g. date of birth, sex, age, contact information, health insurance information and authorization (if applicable)
 |

*To contact the Referrals department directly please call 615-314-4720*

\*Appointment date and time confirmations will be faxed to the requesting providers upon scheduling

\*Consultation or progress notes will be faxed to the referring provider after the patients visit.

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