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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