VISTA RADIOLOGY, P.C.

VISTA INTERVENTIONAL CARE CENTER

Consult Referral Form

Please Fax Completed Form and Documentation to (855) 576-9960

Provider: ☐ First Available ☐ Conrad ☐ Emanuel ☐ Hoss ☐ Roesch ☐ Woodward
☐ DePolo ☐ Hixson ☐ Phillips ☐ Wegryn

Referral Date: _____

Referring Provider:

Practice & Physician Name: _____

Phone Number: _____ Fax Number: _____

Contact Person: _____ Phone Number: _____

Patient Information:

Full Name: _____ Date of Birth (DOB): _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ ☐ Cell ☐ Home

Referral Reason: _____

Diagnosis: _____

Is the patient aware of this referral? ☐ No ☐ Yes

Does the patient need a translator? ☐ No ☐ Yes – if yes, language: _____

Has the patient had any prior imaging related to this condition? ☐ No ☐ Yes

If Yes, list type(s) of imaging (e.g. CT, MRI, US, X-ray), date(s) and facility: _____

1) Primary Insurance Company: _____

Policy Holder Full Name: _____

Policy ID Number: _____ Group Number: _____

2) Secondary Insurance Company: _____

Policy Holder Full Name: _____

Policy ID Number: _____ Group Number: _____

Please send the following with referral request: (Missing information may cause a delay in processing.)

- ☐ Patient demographic information: including copies of insurance cards (front and back)
- ☐ All pertinent medical records and imaging reports
  - If imaging was performed outside of a Covenant facility, referring office **MUST** mail an imaging disc before a patient can be scheduled. Please list date disc was mailed: _____
  - Discs should be mailed to: **Vista Interventional Care Center**
    6344 Lonas Spring Drive
    Knoxville, TN 37909
    (865) 247-8422

FOR OFFICE USE ONLY

Appointment Date: _____ Time: _____am/pm Arrival Time: _____am/pm

Provider: _____ Location: ☐ Ft. Sanders ☐ Parkwest ☐ Vista Interventional Care Center

Paperwork: ☐ Mailed ☐ Patient to Arrive Early

Scheduled By:_____ Date:_____

Patient Notified By:_____ Date:_____