



Email or Fax Referral to UCPMreferrals@utmck.edu
(865)305-4025

Referral Date: _____

New Patient Referral Form

Requested UCPM Physician _____ First Available

Referring Provider _____

Physician Name

Phone No

Fax No

PATIENT INFORMATION (Please submit full patient demographic page with referral)

Last Name

First Name:

DOB

Home Phone

Cell Phone

Email Address

REFERRAL TYPE

Interventional Referral – Opioid therapy will **NOT** be considered as part of evaluation

Comprehensive Referral – Opioid therapy **MAY** be considered as part of evaluation

Do any of the following apply?

Blood Thinners Yes

Pacemaker Yes

Other Implanted Device Yes

PAIN COMPLAINT (What is the main area/location of pain?)

Has the patient had a **previous surgery in the area to be treated?** _____

Please include the following Radiological study of affected pain within 2 years of referral date. Progress

Notes dated within 3 months of referral date.

INSURANCE INFORMATION (Please submit a front and back copy of insurance cards)

Primary Insurance

Insurance _____

ID # _____

Secondary Insurance

Insurance _____

ID # _____