SEMMES MURPHEY

The Jackson Clinic

REFERRAL FORM

Date: ____________ Contact: ____________

Email: *online_appointments@semmes-murphey.com* Referring MD: ____________

Fax: 901.259.2034 Phone: ____________

Phone: 901.522.7700 Fax: ____________

PLEASE ATTACH A DEMOGRAPHIC SHEET, COPY OF HEALTH INSURANCE CARD (CARRIER/ID), TREATMENT NOTES AND IMAGING REPORTS.

CONFIDENTIALITY NOTE: THE INFORMATION CONTAINED IN THIS FACSIMILE MESSAGE IS LEGALLY PRIVILEGED AND CONFIDENTIAL INFORMATION INTENDED ONLY FOR THE USE OF THE INDIVIDUAL OR ENTITY NAMED ABOVE. IF THE READER OF THIS MESSAGE IS NOT THE INTENDED RECIPIENT, YOU ARE HEREBY NOTIFIED THAT ANY DISSEMINATION, DISTRIBUTION, OR COPYING OF THE TELECOPY IS STRICTLY PROHIBITED. IF YOU HAVE RECEIVED THIS TELECOPY IN ERROR, PLEASE IMMEDIATELY NOTIFY US BY TELEPHONE.

PATIENT INFORMATION

Patient Name: ____________ DOB: ____________ Phone: ____________

Address: ____________

Primary Insurance: ____________ ID#: ____________

Secondary Insurance: ____________ ID#: ____________

First Available: ____________ or Requested Semmes Murphey Provider: ____________

Preferred Office Location: ____________

Diagnosis/Reason for Referral/Current Symptoms: ____________

Question	Response	Details
Has the patient had imaging related to the issue? ***(Patient must bring CD of imaging to appointment.)***	☐ Yes ☐ No	**Date of imaging:**
Is the patient's issue related to a Motor Vehicle Accident (MVA)?	☐ Yes ☐ No	**Date of MVA:**
Is there or could there potentially be a Worker's Compensation Claim?	☐ Yes ☐ No	**Date of injury:**
Does the patient have an attorney related to the issue?	☐ Yes ☐ No	
Has the patient had previous spine surgery?	☐ Yes ☐ No	**Date of surgery:** **Name of surgeon:**
Is this an URGENT request?	☐ Yes ☐ No	**Comments:**

Stroke/TIA Referral Patients Only:

Question	Response	Details
Date of Stroke/TIA:		
Was the patient hospitalized?	☐ Yes ☐ No	Date & Where:
Has the patient been seen by a provider for Stroke/TIA?	☐ Yes ☐ No	Provider name:

Has the patient had the following? Please give dates

Patient must bring CD of imaging to appointment

MRI: ☐	ECGO(TTE): ☐	30 Day Heart Monitor: ☐
MRA: ☐	TEE: ☐	Holter Monitor: ☐
CT: ☐	Lipid Panel: ☐	Hypercoagulable Panel: ☐
CTA: ☐	HgbA1c: ☐	

Results of imaging?