



Vista Radiology, PC
 2001 Laurel Avenue, Ste N 304
 Knoxville, TN 37916
 Office: 865-595-4100
 Fax: 865-525-6811

New Patient Referral Form

Please Fax Completed Form to (865) 525-6811

Provider: Conrad DePolo Emanuel Hixson Hoss
 Phillips Roesch Wegryn Woodward

Location: First Available Ft. Sanders Parkwest

Referral Date: _____

Patient Name: _____

DOB: _____

Address: _____

Reason for Referral: _____

Diagnosis: _____

Primary Insurance: _____

Member ID: _____

Insured Member: _____

Group Number: _____

Secondary Insurance: _____

Member ID: _____

Insured Member: _____

Group Number: _____

Referring Provider: _____

Phone: _____

Fax: _____

Contact Person: _____

Phone: _____

Please send the following documentation with referral request:

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, patient **MUST** bring a disc

If patient does not bring imaging disc, the appointment is subject to reschedule

It is preferred that any imaging discs be sent with referral

Discs can be mailed to the address above

OFFICE USE ONLY:

Appointment Date & Time: _____

Location: _____

Scheduled By: _____

All new patients will receive a mailed new patient packet that must be completed and returned to the office at the time of their appointment.