VISTA RADIOLOGY, P.C.

VISTA INTERVENTIONAL CARE CENTER

New Patient Referral Form

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

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

Location: ☐ First Available ☐ Ft. Sanders ☐ Parkwest ☐ Vista Interventional Care Center

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: _____

_____

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 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 an imaging disc
  - If patient does not bring imaging disc, the appointment is subject to rescheduling
  - It is preferred that any imaging discs be sent with referral
  - Discs can be mailed to either address below:

Vista Interventional Care Center
6344 Lonas Spring Drive
Knoxville, TN 37909
(865) 247-8422

Vista Radiology, PC
2001 Laurel Avenue, Suite 304
Knoxville, TN 37916
(865) 595-4100

FOR OFFICE USE ONLY

Appointment Date and Time: _____ _____am/pm

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

Scheduled By:_____ Date:_____