Surgery Referral Form

Date: ___/___/___

To begin our assessment the following information is **required**. Please use the form to ensure **ALL REQUIRED** documents are received. Please send the patient's records and demographics (**including a copy of driver's license and insurance card**). The required information and financial clearance must be received ***before referrals are processed***. Please fill out form entirely. **Any incomplete or missing information will result in the referral being delayed.**

Patient Information: Name (Mr/Mrs., First-middle-last, Jr/Sr): _____

Language: _____ Race: _____ Ethnicity: _____ Gender: M F SSN#:_____

Address: _____City _____State _____ Zip _____

Phone#: (_____)_____ DOB: _____Age: ___

Reason for referral: _____ Diagnosis:_____

******REQUIRED CLINICAL INFORMATION TO PROCESS THIS REFERRAL******

☐ Recent H & P ☐ Admission & Discharge Summary (within 1 year) ☐ Specialist Consultations, and Pathology Reports
☐ List of current medications ☐ Chemistry/ Hematology Results (Current/within 1 year) ☐ Cine films
☐ Related Pulmonary Testing/Procedures: (PFT/ Desat Test/6 min walk) ☐ CXR, EKG & CT Report

☐ Operative reports: Cardiac/Pulmonary/Abdominal ☐ Thallium/Stress Test Results ☐ C-peptide if KP referral

☐ **Cystic Fibrosis patients only:** Genetic Testing and CF database ID#

Referring MD: _____ Specialty: _____

Address: _____City_____ State _____Zip _____

Phone #: (_____)_____ FAX #: (_____)_____ Contact Person:_____

PCP: _____Address:_____

Phone# (_____) _____ FAX#(_____) _____

Insurance Information: If patient has HMO plan, they must provide copy of referral authorization prior to first appointment.

Insurance Co #1: _____
Insured: _____
Insured DOB#: _____
Policy#: _____
Group#: _____
Phone# _____

Insurance Co #2: _____
Insured:_____
Insured DOB#: _____
Policy#: _____
Group#: _____
Phone# _____

Has the insurance company been notified of referral? YES ☐ NO ☐ Authorization #: _____

PLEASE FAX INFORMATION TO:

TGMG Case Management Department
409 Bayshore Blvd Tampa, FL 33606
Phone: (813) 844-5507
Fax#: (813) 844-1921

FOR OFFICE USE ONLY

MR#: _____ **Referral#:** _____

Comments:

_____

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Revised 7/10/13 ER