TENNESSEE
INTEGRATIVE
HEALTH

210 25th Avenue North Suite 521 ▯ Nashville, TN 37203 ▯ Tel: (615) 647-7226 ▯ Info@tennesseeih.com

REFERRAL FORM

Patient information

Name_____ Date of Birth_____

Address_____ City_____ State_____ Zipcode _____

Phone_____ Alt Phone _____ E-mail _____

Insurance Information

Insurance Company_____Employer _____

Insurance Co. Address _____ City _____ State _____ Zip _____

Nurse Case Manager_____ Phone _____Fax _____

Claims Examiner _____ Phone _____ Fax _____

E-Mail _____ Claim Number _____ Date Of Injury _____

Treating Physician Information

Treating Physician _____ Phone_____

Fax _____ E-Mail _____

Service Requested

Functional Restoration Consult/ Initial Evaluation Functional Restoration Program	Please Attach The Following Documents →Authorizations →Initial Consult/Visit report with PTP →Two most recent follow-up visits →Any pertinent QME, AME, Diagnostic Report

Referral Party Information

Name_____ Date _____

Address_____ City_____ State_____ Zipcode _____

Phone_____ Alt Phone _____ E-mail _____

Please Fax Completed Referral Form to (615)835-3487 or Email to info@tennesseeih.com