



TENNESSEE ORTHOPAEDIC ALLIANCE

FAX REFERRAL FORM

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**Joint Replacement,
Shoulder & Sports Medicine**

☐ Jeffrey P. Lawrence, M.D.

DATE: _____ FROM _____ PHONE: _____
REFERRING MD: _____ FAX: _____
CONTACT PERSON: _____ NUMBER OF PAGES: _____

PATIENT INFORMATION

NAME: _____ DOB: _____

PHONE: _____ CELL: _____ WORK: _____

REFERRED FOR: ☐ SPINE ☐ HIP
☐ SHOULDER ☐ KNEE
☐ ELBOW ☐ FOOT / ANKLE
☐ HAND / WRIST ☐ OTHER

DIAGNOSIS: _____

PLEASE FAX PERTINENT MEDICAL RECORDS, TESTS, AND INSURANCE CARDS

FOR TOA STAFF USE

Communication with Patient _____

APPOINTMENT DATE: _____ TIME: _____

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