THE SURGICAL CLINIC

VASCULAR SURGERY
New Patient Fax Referral Form

Date: _____

Referring Provider: _____

Office Contact Person: _____

Office Phone: _____

Patient Name: _____

Patient Phone: _____ Date of Birth: _____

Name of Insurance: _____ Policy Number: _____

Reason for Referral:

_____ Abdominal Aortic Aneurysm
_____ Carotid Artery Disease
_____ Dialysis Evaluation
_____ Leg Pain
_____ Leg Ulceration
_____ Mesenteric/Renal Arterial
_____ Occlusive Disease
_____ PVD/PAD
_____ Other: _____

Requested Provider (please circle below)

St. Thomas West
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Nashville, TN 37205
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FAX: 615.297.9161

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356 24th Ave. N., #300
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Bryan T. Fisher, MD
Allen P. Lee, MD

Skyline
3443 Dickerson Pk., #600
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Southern Hills
393 Wallace Rd., #301, Bldg. A
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Mark W. Shelton, MD

Summit
660 S. Mt. Juliet Rd., #230
Mt. Juliet, TN 37122
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FAX: 615.871.9682

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Columbia – Mid-South Surgeons
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Columbia, TN 38401
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FAX: 931.388.3401

Brian Kendrick, MD
James W. Richardson Jr., MD, FACS
Patrick C. Yu, MD

Once we receive your referral information, we will contact the patient to coordinate and make an appointment time.
VISIT TSCLINIC.COM TO SEND DIGITAL REFERRAL THROUGH OUR WEBSITE.