THE SURGICAL CLINIC

BARIATRIC SURGERY
New Patient Fax Referral Form

Date: _____

Referring Provider: _____

Office Contact Person: _____

Office Phone: _____ Fax: _____

Patient Name: _____

Patient Phone: _____

Diagnosis/Reason for Referral: _____

Please fax the following information with referral form:

- Demographics/insurance cards (front/back)
- All recent testing results (imaging/labs/path reports)
- Patient must bring copy of films for review at time of appointment
- Recent office visit notes
- Current medication list

Requested Provider (please circle below)

Downtown Clinic
410 42nd Ave. N., Ste. 400
Nashville, TN 37209
TEL: 615.329.7887
FAX: 615.340.4537

Surgeon

George B. Lynch, MD, FACS

James G. McDowell, MD, FACS

Southern Hills
393 Wallace Rd., #301, Bldg. A
Nashville, TN 37211
TEL: 615.425.0550
FAX: 615.833.8287

Surgeon

Patrick T. Davis, MD, FACS

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.