VANDERBILT-INGRAM CANCER CENTER

Patient Referral Form

Phone: 615-936-8422, Option 1
Referral Fax: 615-322-4145
New Patient Records Fax: 615-322-6004
Upload Images Using: VanderbiltHealth.com/imageshare

To refer a patient, complete this form and fax to the referral fax number. Additionally, send all applicable new patient records to the new patient records fax number. If you have more questions, call to speak to a referral coordinator.

NASHVILLE

Belle Meade
6002 Highway 100
Nashville, TN 37205

Main Campus
2220 Pierce Ave.
Nashville, TN 37232

One Hundred Oaks
719 Thompson Lane
Nashville, TN 37204

Village at Vanderbilt
1500 21st Ave. S., Suite 2500
Nashville, TN 37212

FRANKLIN
324 Cool Springs Blvd.
Franklin, TN 37067

2105 Edward Curd Lane
Franklin, TN 37067

HENDERSONVILLE
129 N. Anderson Lane
Hendersonville, TN 37075

LEBANON
1616 W. Main Street
Suite 101
Lebanon, TN 37087

PLEASANT VIEW
6536 Highway 41A
Pleasant View, TN 37146

SPRING HILL
1003 Reserve Blvd.
Suite 240
Spring Hill, TN 37174

Date: _____

PATIENT INFORMATION

Patient name: _____ **Date of birth:** _____

Phone: _____ **Email:** _____

Insurance company: _____

Subscriber name: _____ **Subscriber ID:** _____

Referral reason/diagnosis: _____

Has the patient previously been seen regarding this diagnosis: ☐ **Yes** ☐ **No**

Is the patient currently undergoing treatment for this diagnosis: ☐ **Yes** ☐ **No**

Is the patient seeking specific care for this diagnosis: ☐ **Surgical** ☐ **Medical** ☐ **Transplant**

Is this a request for a second opinion? ☐ **Yes** ☐ **No**

Is this a request for a clinical trial? ☐ **Yes** ☐ **No** **If yes, please indicate clinical trial:** _____

Is there a specific provider being requested? If yes, who? _____

Does the patient have a location preference? ☐ **Nashville** ☐ **Cool Springs/Franklin** ☐ **Hendersonville** ☐ **Lebanon** ☐ **Pleasant View** ☐ **Spring Hill** ☐ **No Preference**

(Please note, based on the patient's diagnosis, some locations may not offer services specific to their care)

REFERRING PROVIDER

Name: _____ **Office phone:** _____

Practice: _____ **Office fax:** _____

Comments:

Some clinics are designated as hospital-based. To learn more, go to VanderbiltHealth.com/hbc