East Tennessee Children's Hospital Pediatric Neurology
2100 W Clinch Ave, Suite 210
Knoxville, TN 37916
p. (865) 523-5437
f. (865) 523-3559

Patient Consultation Request Form

Fax **COMPLETED** form, medical records, and insurance card(s) (front and back) to East Tennessee Children's Hospital Pediatric Neurology. For questions, please call our office. Allow up to **3** business days for scheduling.

PART I - REFERRING PHYSICIAN INFORMATION

Today's Date: ____________________ Practice Name: ______________________________

Referring Physician: ______________________________ NPI#: ______________________

Address: ____________________________ City: ______________ State: _____ Zip: ________

Contact: ____________________________ Phone: ______________ Fax: ________________

PART II - PATIENT INFORMATION

Patient Name: ______________________________ DOB: __________ SSN: ______________________
(First, Middle Initial, Last) **(required for TennCare patients)**

Gender: ☐ M ☐ F Interpreter Needed? ☐ Y ☐ N Specify Language: ______________________

Address: ____________________________ City: ______________ State: _____ Zip: ________

Primary Phone: ______________________________ Secondary Phone: ______________________

Insurance(s): ______________________ (PRIMARY) ______________________ (SECONDARY)

Is this child in foster care? ☐ Y ☐ N Case Manager Name: ______________ Phone: ____________

PART III - GUARANTOR INFORMATION

Guarantor Name: ______________________________ Relationship to Patient: ______________________

DOB: ____________________ SSN: ____

PART IV - APPOINTMENT INFORMATION

Presenting Diagnosis/Problem: ____

Please circle specific provider or first available for scheduling:

Karsten Gammeltoft, M.D. Anna Kosentka, M.D. Jessica Sheah, M.D. First Available

Amy Long, P.A. (migraine or tic patients not yet started on daily medication)

Additional Comments: ____

WE MUST RECEIVE A COMPLETED CONSULTATION REQUEST FORM, MEDICAL RECORDS, AND A COPY OF THE INSURANCE CARD (FRONT AND BACK) BEFORE AN APPOINTMENT WILL BE SCHEDULED. Once the appointment is scheduled, our office will fax this form back to you. Your office will need to inform the patient.

FOR OFFICE USE ONLY - DO NOT WRITE BELOW THIS SECTION

Appointment Date: ______________________________ Arrival Time: ______________________

Physician: ______________________________ Informed Referring Office: ______________________

Form No. 33434 (09/2022)