Fax or Email: (_____ **Total Pages**)

To: Sheryl Seschille, TCRHCC Radiology Scheduling MSA

Phone: (928) 283-1445 **Fax:** (928) 283-1447 **Email:** Sheryl.Seschille@tchealth.org

From: _____

Phone: _____ **Fax:**_____**Email:**_____

Date: _____

Re: **Referring Provider Information**

Ordering Provider's Information:

Printed/Typed Name and Credentials: _____

NPI# (10 digits):_____

Active State License: Number:_____ State:_____

Preferred Method of Contact for TCRHCC Reporting of Urgent or Critical Results to you:

☐ Phone Call ☐ Cellular Text Message ☐ Email ☐ Other:_____

Phone Number:_____ ☐ This is a cellular phone

Email:_____

Comments:_____

_____

_____

Please Complete and Submit this page once for <u>EACH</u> Medical Facility and/or Department from which you will be Initiating TCRHCC Imaging Referrals.

Medical Facility:_____

Department: _____

Department/Clinic Phone Number: _____

Facility Fax Number (Non-Urgent Reports): _____

Are you a Permanent or Temporary Staff Member or this Facility / Department (circle)?

☐ Permanent ☐ Temporary

If Temporary, when does you assignment end?_____(date)

<u>Back-up Provider Contact Information:</u>

(Back-up Provider must be located at the same Facility):

When you are on vacation, when your temporary assignment has ended, or when you are not able to be successfully contacted within 20 minutes, you want <u>urgent/critical reports</u> to be called in to:

☐ **the _____Service/Department Provider on Call**

Phone to be connected to the provider on call:_____

☐_____

(Back-up Provider Name, Credentials, Department at the Same Facility as Referring Provider)

☐ Phone Call ☐ Cellular Text Message ☐ Email ☐ Other:_____

Phone Number:_____ ☐ This is a cellular phone

Email:_____

Comments:_____

_____

***Note: <u>Non-urgent</u> study results will continue to be faxed to your attention, at the facility fax number, even when you are on vacation or no longer working at the facility. Your facility is responsible for making arrangements, as necessary, for the reviewing/processing of these results, in your absence.**

Referring Provider Signature:_____**Date:**_____

The Referring Provider attests that the above information is correct and will be updated immediately, as changes occur.

Back-up Provider Signature (as applicable):_____**Date:**_____

The Back-up Provider attests that the above information is correct and will be updated immediately, as changes occur.