Threlkeld, Threlkeld, and Omer, PLLC
6029 Walnut Grove Road, Suite C002
Memphis, TN 38120
Phone: 901-685-3490 Fax: 901-685-3499

New Patient Referral Form

Name of Referring Physician: ______________________________________

Office Fax #: ____

Office Contact: __________________________ Contact Phone #: __________________

Patient's Name: ____

Patient's DOB: ____

Patient's Phone Number(s): ____

Diagnosis / Reason for referral: ____

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Does patient need to be evaluated for either or all of the following services?

__ Wound Care (If not currently receiving WC service elsewhere)
__ IV Antibiotic (Infusion Center)
__ IV Antibiotics (Home)

Has patient ever been seen by an Infectious Disease Physician? If Yes, who?
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Please complete the above information and fax this form with an *updated medication list, Patient Demographics, Patient Insurance Cards (front and back), Office Notes or Letter Regarding Referral, Most Recent Labs, Cultures, and Diagnostic Reports Pertaining to Referral*

****NOTE: For urgent referrals for the Infusion Center, your physician should directly contact one of our providers to determine the best treatment plan. If patient is currently hospitalized, our physicians may be consulted during the inpatient stay to establish treatment plan prior to discharge. Insurance benefits are reviewed prior to scheduling and treatment.**