



# FRESH START MEDICINE

*Where Your Recovery Begins*

## REFERRAL FORM

### Referral Information

Patient:	DOB:	Phone:
Email:	Preferred Contact Name & Relationship:	
Address:		
Insurance Plan Name:	Insurance Policy ID:	
Referred For (check all that apply): <input type="checkbox"/> Medication Assisted Treatment (MAT) <input type="checkbox"/> Primary Care <input type="checkbox"/> Other: _____		
Patient's Preferred Practice Location: <input type="checkbox"/> Kingsport <input type="checkbox"/> Rogersville <input type="checkbox"/> Knoxville		

### Referring Provider Information

Name:	Organization/Group Name:	Location:
Phone:	Fax:	Email:
Comments: _____ _____ _____ _____		

**Kingsport:** 1700 Pinebrook Drive Ste 4, Kingsport, TN 37660 ♦ Phone: (423) 251-6670 ♦ Fax: (423) 251-1899

**Rogersville:** 3815 Highway 66 S Ste 4, Rogersville, TN 37857 ♦ Phone: (423) 922-9211 ♦ Fax: (423) 922-9301

**Knoxville:** 930 Adell Ree Park Lane, Knoxville, TN 37909 ♦ Phone: (865) 769-2600 ♦ (865) 769-2616