



Appointment Flow Sheet

Affix Patient Label

Full Legal Name:

[REDACTED]

MRN:

[REDACTED]

Home Phone Number:

(423) 626-0505

SSN:

[REDACTED]

DOB:

4/26/34

RefPhys Phone#: (865) 690-4861

Insurance Information:

UHC MC COMPLETE

DX: HIP PAIN

Dept Time: 4/25/17 3:00 pm

Procedure Time: 3:00 pm

Dept: XRAY (in-75192 out-31503)

[REDACTED]

Ref Phy: PARSONS, RICK E

XR INJECTION LT HIP *PRIOR 11/22/16*

☐ Lab

[REDACTED]

☒ Cardio

[REDACTED]

☒ Pulm

[REDACTED]

☐ XRay

[REDACTED]

☐ Other

[REDACTED]

[REDACTED]

☐ EKG

Patient type: _____

Send: _____

Location: _____

Service: _____