Advanced Spine & Pain Management

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FAX REFERRAL FORM

PATIENT INFORMATION

PATIENT NAME: _____DOB_____ SS#:_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

HOME PHONE: ( ) _____ WORK: ( ) _____CELL: ( ) _____

CHIEF COMPLAINT:_____

☐ **CONSULT ONLY** ☐ **EVALUATE & TREAT** ☐ **MEDICATION MANAGEMENT** ☐ **INJECTION ONLY**

INSURANCE INFORMATION

PRIMARY:_____ PHONE NUMBER ( )_____

ID NUMBER: _____ GROUP NUMBER: _____

SECONDARY: _____ PHONE NUMBER ( ) _____

ID NUMBER: _____ GROUP NUMBER: _____

BWC CLAIM: MCO _____DOI _____ CLAIM # _____

REFERRING DOCTOR INFORMATION

REFERRING DOCTOR: _____ NPI: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE NUMBER: ( ) _____ FAX: ( ) _____

OFFICE CONTACT: _____ DIRECT LINE: ( ) _____

PLEASE ATTACH THE FOLLOWING:

- ☐ COPY OF LAST 3 OFFICE NOTES
- ☐ COPY OF ALL RADIOLOGY REPORTS (MRI, CT, X-ray)
- ☐ COPY OF INSURANCE CARDS
- ☐ COPY OF MEDICATION LIST *PLEASE INCLUDE ALL NARCOTICS*
- ☐ COPY OF SURGICAL LIST

HAS THE PATIENT EVER BEEN SEEN BY A PAIN DOCTOR _____ when _____ where_____

HAS THIS PATIENT EVER BEEN DISCHARGED FROM A PAIN CLINIC OR FOR NARCOTIC ABUSE ( ) YES ( ) NO
Advance Spine & Pain Management does not accept previously discharged patients or prior narcotic abuse.