



# Pain Management Referral Form

Phone: (937)252-2000

Fax: (937) 252-3700

*\*Please Provide All Requested Patient Info, Incomplete referrals may delay process*

## Patient Information

Patient Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_  
(primary)

SSN: \_\_\_\_\_  
(secondary)

Insurance: \_\_\_\_\_

Satellite Offices: Does the patient have a preference for any of the following offices?

Woodman  Dayton Mall  Huber Heights  Troy  Springfield  Greenville

## Referring Physicians Info

Phone: \_\_\_\_\_

Physician Name: \_\_\_\_\_

Address: \_\_\_\_\_ Fax: \_\_\_\_\_

UPIN# \_\_\_\_\_ NPI#: \_\_\_\_\_

Email: \_\_\_\_\_

### Pain Management

Evaluate & Treat  Injection Therapy  Spinal Cord Stimulator/  
Intrathecal Pump Eval

Diagnosis: \_\_\_\_\_

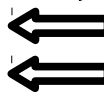
Comments: \_\_\_\_\_

### Required Documentation for all Referrals in Date Order (Most Recent First):

\*Please send any pertinent Testing (MRI / CT / EMG / List of Meds / etc.)

\*Demographics sheet including copy of their insurance card.

\*Last two office notes in date order.



Please send all requested documentation with the referral for faster scheduling. Thanks!

Physicians Signature: \_\_\_\_\_ Date: \_\_\_\_\_