

FAX REFERRAL FORM

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INTERVENTIONAL SPINE & PAIN

T A R G E T E D C A R E . M E A N I N G F U L R E L I E F .

Please fax all referrals to **800-940-9601**. If you experience any transmission errors or have questions, please call **(269) 266-3104**. Kindly include all appropriate patient medical information for our central scheduling team. We will contact your patient to schedule the initial consultation at the first available appointment and will notify your office with the appointment details.

Date: _____ Patient Name: _____
Date of Birth: _____ Home Phone No: _____
Referring Physician: _____ Phone No: _____ Fax No: _____
Referring Office Contact: _____ PCP : _____
PCP Phone No: _____

Demographics are included with this fax

Copy of insurance card is included with this fax

Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	Spouse's Name: _____
Patient Address: _____	
Employer: _____	
Is this Work or Auto related? <input type="checkbox"/> No <input type="checkbox"/> Yes, if yes, please provide the Claim No: _____	
Date of Injury: _____	Insurance Carrier: _____
Adjuster Name: _____	Phone No: _____
Primary Insurance: _____	
Contract No: _____	Insured Name: _____
Group No: _____	Employer: _____
Secondary Insurance: _____	
Contract No: _____	Insured Name: _____
Group No: _____	Employer: _____

Diagnosis: _____

Reason for Referral:

Records - In order to schedule your patient, please send the following records with your referral:
(Please note, if applicable records have not been received, the patients appointment may be delayed)

- Previous pain management records..... None
- Most recent imaging related to diagnosis..... None
- Current medication list..... None
- Most recent chart notes related to diagnosis..... None
- Initial evaluation and discharge summary for previous physical therapy related to diagnosis..... None