ADVANCED PAIN CARE CLINIC, PSC

# PATIENT REFERRAL - EAST SIDE CLINIC

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## PLEASE INCLUDE OFFICE NOTES AND RADIOLOGY / DIAGNOSTIC REPORTS

REFERRING PROVIDER _____ NPI # _____

REFERRAL CONTACT _____ EMAIL ADDRESS _____

DATE____/____/_____ PHONE NUMBER _____ FAX NUMBER _____

ADDRESS _____CITY _____ ST_____ZIP _____

PATIENT NAME _____ EMAIL ADDRESS_____

PHONE NUMBER_____ DOB_____/_____/_____ SS#_____-_____- _____

ADDRESS _____ CITY_____ ST _____ ZIP_____

REASON FOR REFERRAL _____

- ❒ EVAL & TREAT
- ❒ EVALUATE FOR SPINAL CORD STIMULATOR
- ❒ EVALUATE FOR INTRATHECAL PAIN PUMP
- ❒ SPECIFIC PROVIDER REQUESTED _____
- ❒ OTHER _____

## PATIENT INSURANCE INFORMATION

(PLEASE FILL OUT OR SEND FACE SHEET)

**WORKERS COMP?** ❒ YES ❒ NO **APPROVED?** ❒ YES ❒ NO **AUTO?** ❒ YES ❒ NO CERT CODE/ATH _____

INSURANCE CARRIER _____ PHONE NUMBER _____

INSURED'S NAME/RELATIONSHIP _____ DOB____/_____/_____ (OF POLICY HOLDER)

EMPLOYER_____ POLICY # _____ GROUP # _____

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