COMPREHENSIVE
Pain Management Center
Defining Excellence in Pain Management

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REFERRAL FORM

Patient Name:____ **Date:** __________________
Referral Source: ____________________________________Contact: ___________________
Ph#: ____________________________________ Fax: _______________________________
Address:_____________________________ City:_____________ State: ___ Zip: __________
Reason for Referral: □ Consult Only □ Consult & Treatment □ Consult & Injections

Please attach the patient's face sheet - OR - Fill in the following information. Thank you.

Patient Information

DOB: _________/_________/________ SS#: ___________-___________-___________
Address: ___________________________________ City: ___________ State: ___ Zip: _____
Primary Phone: __________________________ 2nd Phone: ____________________________
Diagnosis/ICD-9 code: ____
Narrative: ____

Insurance Information

□ Medicare □ Self-pay □ Private □ Workers' Compensation

Primary Treating Physician: ____
Insured (i.e. self, spouse): _________________________ DOB of insured: ______/_____/____
Insurance: ____
Address: __________________________________City: ___________ State: ____ Zip: ______
If Workers' Compensation, Claim #: ________________________ DOI: _____/______/_____
Adjuster: ____________________________ Ph #: ________________ Fax: ______________
Authorization Obtained: □ YES □ NO Date: _____________Authorized By: ______________
Interpreter Needed: □ YES □ NO If yes, what language: _______________________________

In order to expedite processing the referral, **ALL** of the following items must be received. If all the information is not received within 30 days from the initial request, the referral will not be able to be processed and all records will be destroyed. Upon receipt of this information and verification of insurance the patient will be scheduled for a consultation **ONLY**.

□ Face sheet with patient information
□ Insurance information: Work Comp/Private Insurance/Medicare (copy of both sides of card)
□ Insurance Authorization, if needed
□ History & Physical/Progress Notes
□ MRI Report

Fax to (408) 356-5307

Internal Use Only Appt date: __________________ Time: ___________