ADVANCED PAIN MEDICINE ASSOCIATES

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PAIN MANAGEMENT REFERRAL

Today's Date: _____

Referring Physician: _____ Phone: _____ Fax: _____

Office contact person: _____ Phone: _____ Extension. _____

Patient: _____ DOB: _____ Phone: _____

Diagnosis: _____ Has the patient been seen by other Pain Specialist? □Y □ N

Primary Care Physician: _____ Currently on pain medications? □Y □ N Last Rx: _____

□ **Evaluate & Treat: Patient will be evaluated and treated based on the provider's discretion and appropriateness for the diagnosis and symptoms.**

□ **Procedures Only: Patient will be seen for appropriately indicated procedures; medications will still be managed by referring physician/ primary care.**

THE FOLLOWING MUST BE FAXED

1. **ALL patient demographic** information with **CURRENT PHONE NUMBERS.**
2. **CLEAR COPY of insurance card(s),** Front & Back please. If **MVA** please provide accident date, insurance company and claim number. If **WORK COMP** please provide billing information, claim number and work comp contact information.
3. **ANY DIAGNOSTIC/SCAN REPORTS AND OFFICE NOTES** related to the diagnosis.

******WE DO NOT ACCEPT ANY FORM OF MEDICAID/KANCARE INSURANCE******

We appreciate your referral and look forward to providing quality care for your patients.
New Patient Coordinator - Tel: 316.942.4519 opt. 4 Fax: 316.942.4655