Diagnostic or Therapeutic Procedure Request

Anesthesiology and Pain Consultants, Inc.

REFERRAL INTAKE FORM

(Must be completed for all referrals)

Patient Name:	Referring MD:
Patient DOB: Sex: M or F	Patient SS#:
Patient Phone: Alt. Phone:	Patient Address: City: State: Zip Code:
INSURANCE INFORMATION	
Primary Insurance/WC Company:	Policy/Group/Claim #: WC fax#:
Insurance Precert/Benefits Phone #:	Insurance Address:
Name of Subscriber:	WC Adj. Name: DOI:
Secondary Insurance Company:	Policy/Group #:
Insurance Precert/Benefits Phone #:	Insurance Address:
Name of Subscriber:	

Clinical and Medical/Surgical History

Has patient seen another pain physician? Whom?
____

Refer to: Dr. _______________________(or) [ ] First Available

Medical Diagnosis (related to referral): ____________________

Reason for referral :
(Check one: unable to process without this information):

- □ Eval & Treat
- □ Cervical, Thoracic and Lumbar Epidural Steroid Injections
- □ Lumbar Transforaminal Injections
- □ Peripheral Nerve Blocks
- □ Trigger Point Injections
- □ Spinal Cord Stimulators
- □ Stellate or Lumbar Sympathetic Blocks
- □ Joint Injections
- □ Sacroilliac Joint Injections
- □ Other _______________________

Current Medication: _______________

Blood Thinners:

Please send a copy or your patient's:
*****H&P*****
*****Pertinent Office Notes*****
*****CT or MRI*****
So we can better treat your patient.

Please note that patients addicted to medication are more appropriately referred to psychiatrists specializing in addictionology