ADVANCED PAIN TREATMENT

Phone: 608-580-8252
Fax: 866-950-0314

# Patient Referral Form

**Please provide:**

- A copy of the last office visit note
- Copies of imaging reports. i.e MRI, CT etc.
- Copy of insurance cards
  (Fax: 866-950-0314)

Date ____________________

Requesting Provider ____________________

Name: ____________________ Fax # ____________________

Please specifically document consultation requests in the patient's medical record. For consultation visits, we will send a complete report to the requesting provider after the patient visit

## PATIENT INFORMATION

First Name ____________________ Last Name ____________________

Patient DOB ____________________

City ____________________ State ____________________ Zip ____________________

Phone # ____________________ Is the injury work-related? ☐ Yes ☐ No

Hx/Diagnosis ____________________

### Type of pain:

☐ Spinal pain

☐ Cervical ☐ Thoracic ☐ Lumbar

☐ Joint pain

☐ Knee ☐ Shoulder ☐ Other

____________________

☐ Neuropathic pain

____________________

____________________

### Reason for visit:

☐ Consultation only ☐ Consultation and treatment (if applicable)

### Special instructions:

☐ Procedure/treatment

____________________

Other ____________________

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