FAX REFERRAL FORM

FAX: 616.588.6175 PHONE: 616.282.0633

www.michiganpain.com

MPC
MICHIGAN PAIN CONSULTANTS, PC

Date: _____ Patient Name: _____

Social Security No: _____ Date of Birth: _____ Home Phone No: _____

Referring Physician: _____ Phone No: _____ Fax No: _____

Referring Office Contact: _____ PCP (if not referring Dr): _____

PCP Phone No: _____

☐ **Demographics are included with this fax** ☐ **Copy of insurance card is included with this fax**

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Spouse's Name: _____

Patient Address: _____

Employer: _____

Is this Work or Auto related? ☐ No ☐ Yes, if yes, please provide the Claim No: _____

Date of Injury: _____ Insurance Carrier: _____

Adjuster Name: _____ Phone No: _____

Primary Insurance: _____

Contract No: _____ Insured Name: _____

Group No: _____ Employer: _____

Secondary Insurance: _____

Contract No: _____ Insured Name: _____

Group No: _____ Employer: _____

Reason for Referral:

☐ Evaluate and Treat	☐ Physical Therapy	☐ Post Surgical Complications
☐ Ketamine	☐ Behavioral Therapy	☐ Medication Treatment Plan
☐ PRP/BMAC	☐ Kyphoplasty	☐ Spinal Cord Stimulator Trial

Diagnosis: _____

_____

Provider:

☐First Available	☐John Birgiolas, MD.	☐Jeff Gao, MD, MPH	☐Scott Greenwald, MD
☐Mark Juska, MD	☐Peter Khoury, DO	☐Eric Kozfkay, DO	☐Bindu Lewis, MPT, DO
☐Austin Marcolina DO	☐Kevin M. Nemeth, MD	☐Adam Powell, DO	☐Lisa Pullum, DO
☐Bennett Willard, DO			

Records - In order to schedule your patient, please send the following records with your referral:
(Please note, if applicable records have not been received, the patients appointment may be delayed)

- ☐ Previous pain management records.....
- ☐ Most recent imaging related to diagnosis.....
- ☐ Current medication list.....
- ☐ Most recent chart notes related to diagnosis.....
- ☐ Initial evaluation and discharge summary for previous physical therapy related to diagnosis.....