M.D. Pain Specialists

Transformation through evidence based care

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FAX REFERRAL

Date: ______________________________

Patient Information: ______________________________

Name: ______________________________ DOB: ______________________________

Phone #: ______________________________ Patient SSN: ______________________________

Chief Complaint: ______________________________

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Referring Physician: ______________________________

Referring Physician Phone #: ______________________________ Fax #: ______________________________

Referring Physician UPIN #: ______________________________

Referring Physician Address: ______________________________

❏ Evaluation Only
❏ Evaluate & Treat

Insurance Carrier: ______________________________

Special Instructions: ______________________________

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Please fax copy of referral form and any applicable medical records.
Patient should bring MRI and/or plain films to consult visit.