APPALACHIAN REGIONAL HEALTHCARE SYSTEM
Appalachian Regional Pain Management Center

Patient Name_____
Date of Birth_____
Phone Number_____
Please Fill in or Affix a Patient Label

Pain Management New Patient Referral Form

Patient Demographics:
Patient Name: _____ DOB: _____
Patient Address: _____
Patient Phone Number: _____ Secondary Phone Number: _____
Patient Primary Insurance: _____
Patient Secondary Insurance: _____

Provider Information:
Referring Provider: _____
Provider Address: _____
Phone Number: _____ Fax Number: _____
Office Contact Person: _____
Patient's pain-related diagnosis (ICD-10):_____
What service would you like us to provide to your patient? Please check one:

- ☐ Consideration for the following procedure: _____.
- ☐ Consultation with subsequent recommendations for pain management.
- ☐ Evaluate and assume responsibility for pain management.

Completed By: _____
Signature: _____ **Date/Time:** _____

Please fax this completed form to the fax number listed below along with:

- **Copy of patient's insurance card(s) front and back (must have before information will be reviewed.)**
- **Copies of 2-3 most recent office notes.**
- **Copies of any imaging reports (X-ray, MRI, CT) that are related to the patient's pain symptoms.**

Once we receive this information, please allow 7-10 business days for our physicians to review it. If we can be of services to your patient, our office will contact the patient directly to schedule an appointment. Should we feel that we cannot provide your patient with the necessary medical treatment(s), our office will contact you directly to inform you.