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Tel: (989) 792-4090  
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## CONSULTATION REQUEST

PLEASE FAX ALL REQUESTS TO: (989) 792-4094

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN# \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work: \_\_\_\_\_

Reason for Consultation (Diagnosis): \_\_\_\_\_

The following are considered emergencies by our providers. Please indicate if pain is related to:

- Cancer     CRPS     Compression Fracture     Shingles

You are requesting:  Consult only and return to physician with report  Evaluate and treat

Previously treated by a Pain Specialist:  No  Yes    Physician: \_\_\_\_\_

Referring Physician Signature: \_\_\_\_\_

**Please fax and/or mail any pertinent labs/ x-ray reports, MRI or Scan results to our attention. Any information on course of treatment or medications would be helpful.**

**REFERRING PHYSICIAN** \_\_\_\_\_ Office Phone \_\_\_\_\_

Address: \_\_\_\_\_ Fax: \_\_\_\_\_

NPI#: \_\_\_\_\_ License: \_\_\_\_\_ UPIN # \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Office Phone \_\_\_\_\_

Address: \_\_\_\_\_ Fax: \_\_\_\_\_

**INSURANCE:** Please Circle (As of 1/2003, we are no longer accepting Medicaid patients)

Medicare    BCBS    HealthPlus    BCN    Work Comp    Auto    Commercial    No Ins

Carrier Name/Adjustor: \_\_\_\_\_ Policy/Claim Number: \_\_\_\_\_

Insurance Co. Phone Number: \_\_\_\_\_ Address: \_\_\_\_\_

Patient's Appointment Date/ Time: \_\_\_\_\_

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