



4450 Fashion Square Blvd.
Saginaw, MI 48603
Tel: (989) 792-4090
www.matrixpain.com

Michael Papenfuse, D.O.
Diane Czuk-Smith, M.D.

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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