Pain & Rehabilitation Consultants

Referral Form

Thank you for choosing to refer your patient to us.

Please include **all** pertinent medical records, to include imaging results and previous pain management records. Please include the patient's insurance card (both sides) and authorization if required.

We have two locations; please **select** which office you prefer:

- ☐ For our Madison location, please fax to 855-301-8314
- ☐ For our Albertville location, please fax to 256-660-1308

Date:_____ From:_____

☐ Consult and Treat

☐ ENFD/EMG Testing

☐ Interventional Procedure

☐ Second Opinion/Consult Only

Title:_____

Phone:_____

Fax:_____

Number of Pgs:_____

Patient Information

Name of Patient:_____

SSN:_____D/O/B:_____Phone#:_____

Mailing Address:_____

City:_____State:_____Zip:_____

Insurance:_____

Diagnosis/ICD-10:_____

By providing the information requested and signing below, you agree that we may initiate treatment following consultation or perform medically necessary diagnostics, in association with this consultation. All patients are subject to Pain & Rehabilitation Consultant's review process. We look forward to collaborating with you on your patient's treatment plan.

Referring Provider Information

Referring MD:_____Specialty:_____
Phone:_____Fax:_____

Provider Signature:_____