MIDWEST PAIN & SPINE

Physician Referral Form

Patient Name: _____ (___) **Date of Birth:** ____/____/____
Last **First** **MI**

Home/Mobile Phone: (_____) _____-_____ **Work Phone:** (_____) _____-_____

Primary Insurance: _____ **Insurance ID#/Group#** _____

Referring Doctor: _____ **Address:** _____

Phone: (_____) _____-_____ **Fax:** (_____) _____-_____

❒ **The patient is looking forward to hearing from your office to schedule an appointment.**

Evaluation Requested

❒ **Spine Management and Take Over Care**

❒ **Evaluation & Treatment**

Previous Medical Records Needed

Included with this referral request is the pertinent medical records on our patient, to allow you to provide a thorough evaluation and take over care if requested.

❒ **Office notes (last three years, if available)**

❒ **Procedure notes (last three years, if available)**

❒ **Current insurance card(s)**

❒ **NO previous records are available**

❒ **MRI's, CT's, other imaging, or testing**

❒ **Patient demographic information**

*** Midwest Pain & Spine Will Complete and Return to Referring Physician ***

Communication to you and our patients is important to our practice. The following is the next step in the patient's continued care. We will keep you updated with their progress.

❒ **Patient is scheduled on (date and time)** _____ **for an appointment.**

❒ **Patient is not appropriate for our practice. We ask that you find another provider to take over care.**

❒ **Other/Comments** _____

_____

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