MIDWEST PAIN & SPINE

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## PROVIDER REFERRAL FORM

**Patient Name:** _____ **Date of Birth:** ____/____/____
**Patient's Full Legal Name**

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

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

**Referring Provider's Name:** _____ **Address:** _____

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

❒ **Contact patient to schedule an appointment.**

## Evaluation Requested

❒ **Spine Management and Take Over Care**
❒ **Evaluation & Treatment**

## Previous Medical Records Requested for Evaluation

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 two office visits)**
❒ **NO previous records are available**
❒ **Procedure notes (last two years, if available)**
❒ **MRI's, CT's, other imaging, or testing**
❒ **Current insurance card(s)**
❒ **Patient demographic information**

## *** Midwest Pain & Spine Will Complete and Return to Referring Provider ***

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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