

INTAKE DATE:		IDX#	
NAME:		Primary Ins.	
ADDRESS:		Secondary Ins.	
CITY/ST/ZIP:		DOB:	
PHONE#:		SS#	
PCP		REF DR	
ADDRESS:		ADDRESS:	
CITY/ST/ZIP:		CITY/ST/ZIP:	
PHONE #		PHONE #	
FAX#		FAX#	

This section to be completed by referring physician.

REASON FOR REFERRAL: Diagnosis/Problem

REQUESTING?

- * **CONSULT ONLY** (Treatment recommendations only) No medications will be prescribed.
- * Procedures (i.e., Nerve block, Epidural Steroid Injections) No medications will be prescribed.
- * Evaluation - Establish treatment plan. Goal oriented/Patient to be released back to referring physician.

HAS THE PATIENT CONSULTED ORTHO, NEURO, P.T. OR OTHER SPECIALIST ?

IF YES, PLEASE PROVIDE CONSULT LETTERS.

WHAT DIAGNOSTIC TESTS HAVE BEEN ORDERED?

X-RAY, CT, MRI, BONE SCAN, DEXA SCAN, MYLEOGRAM, EMG, OTHER?

IF YES, PLEASE PROVIDE RESULTS.

HAS THIS PATIENT BEEN TO PREVIOUS PAIN PROGRAMS?

IF YES, WHEN AND WHERE? **PLEASE PROVIDE CONSULT.**

HAS THIS PATIENT HAD ANY SURGERIES?

IF YES, WHEN AND WHERE? **PLEASE PROVIDE OP REPORT**

This section to be completed by Intake Coordinator

* Additional Information needed:	Consults	Demographics
	Test Results	Insurance Card
* Referral Response: _____		

Referral Tracking:

Call #1	Date/Time: _____	Note: _____
Call #2	Date/Time: _____	Note: _____
* Unable to reach patient. Referring physician notified.	Date/Time _____	

DATE/TIME OF APPOINTMENT: _____ **Akbik** **Munir**

University Pointe Pain Management Center
Phone (513) 475-8282
Fax (513) 475-8283

New Patient Referral Form

* Patient Seen. Consultation report to be faxed to: _____

* Patient Canceled/Did Not Show: notice faxed to: _____

Signature:

Charlene Glover

Intake Coordinator

(513) 475-7545

Date: _____