Medical Pain Management SERVICES, LTD

Facsimile Consultation Form

fax 815.229.0050 phone 815.397.8400

Date _____ Physician Request _____

Physician Requesting Consultation _____

Phone _____ Fax # _____

Reason For Consultation / Referral _____

Patient Information

Name _____

Address _____

City _____ State & Zip _____

Home # _____ Cell # _____ Work # _____

SSN # _____ - _____ - _____ Birth Date _____

Primary M.D. _____ Phone _____

Insurance Information

***** Please include copy of insurance card (front & back) *****

Group Insurance _____ Employer _____

Policy Holder Name _____ DOB _____ ID # _____

Work Comp / MVA Ins _____ Phone _____

DOI: _____ Atty and or Adjustor Name & Phone _____

***** MVA CLAIM - PLEASE INCLUDE COPY OF INDIVIDUAL'S INS INFO ALSO*****

Current Testing & Medical Records

Attach Copy of Report

MRI/X-Ray	No	Yes	Date _____	Location _____
CT Scan	No	Yes	Date _____	Location _____
EMG	No	Yes	Date _____	Location _____

Is the patient taking COUMADIN or other blood thinners? No Yes

Is the patient allergic to any Medications? If YES, what? _____

Is the patient diabetic? No Yes Insulin Diet

Please complete this form in its entirety and include: **Office Notes / Dictation, Insurance Information, Med List, MRI and/or X-Ray Reports to process referral in a timely manner.**

~ Thank You