Referral Form

Reason for Referral:

- ☐ Chronic Pain Management
- ☐ Opioid Use Disorder Management
- ☐ Alcohol Use Disorder Management

Patient Information:

Last Name:	First:	Middle:
DOB:		
Home Address:		
City:	State:	Zip Code:
Home/Cell Phone:		
Alternate Phone:		
Insurance Company Name:		Group Code:
ID/Policy #:		Effective Date:

Referring Provider Information:

Referring Physician:		Specialty:
Contact Name:		
Phone:		Fax:
Address:		
City:	State:	Zip Code:
X **Referring Physician Signature**		**Date:**

Please submit the following to our office:

- Referral from Primary Care Provider.
- Medical Records (including all imaging: CT, MRI, X-rays).
- Current medication list printed off from pharmacy.

(573)693-9080
(417)888-0189
info@epmmd.com
ElitePainManagement.md
5780 Osage Beach Pkwy, Suite 113
Osage Beach, MO 65065

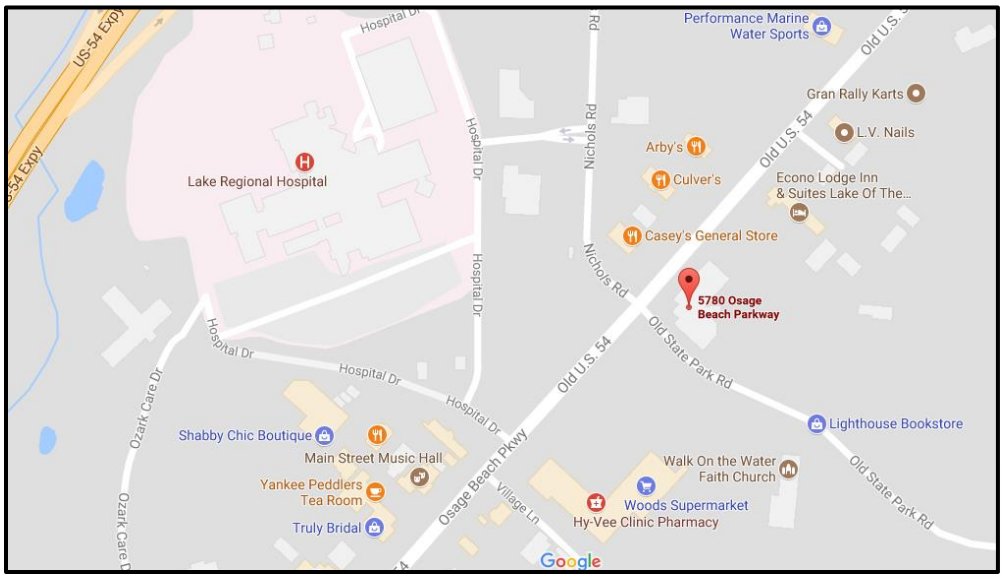
Patient Information Sheet

(Patient handout)

Your provider has referred you to our clinic.
Please call for an appointment within 72 hours.
We look forward to caring for you.

At your visit, we will need the following:

- Current medication list printed off from your pharmacy.
- Bring all medication in the original bottles.
- All payments are due at time of service.
- Photo ID and Insurance card(s) are REQUIRED.



Our address is 5780 Osage Beach Parkway, Suite 113.
Please call (573) 693-9080 with any questions.

Please be advised:

- All patients will have a witnessed drug screen at each appointment.
- Minor children (under 15 years old) are not permitted in the clinic.
- A 24 hour cancellation notice is REQUIRED.

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