REQUEST:

PAIN MANAGEMENT CONSULTATION

Phone (302) 355-0900
Fax (302) 355-0901
Web delmarvapain.com

Date

Requesting Provider NPI #

Phone # ( ) Fax # ( )

Primary Care Physician *(if different)*

Phone # ( ) Fax # ( )

Fax this form to (302) 355-0901

Please include recent office visit notes and any imaging reports along with this form.

PATIENT INFORMATION

First Name Last Name

Patient DOB Phone #: ( )

Insurance Type: ☐ Health Ins ☐ Medicare ☐ Medicaid ☐ MVA ☐ Work Comp

HMO Referral Submitted *(if applicable)*: ☐ YES ☐ NO

Provider NPI #1285994582 • Practice NPI #1750810305

Primary Insurance Secondary Insurance

ID or Claim #: ID or Claim #:

Adjustor: Adjustor's Phone #: ( )

Attorney: Attorney's Phone #: ( )

Date of Injury/Accident:

Other Notes / Information:

TYPE OF PAIN:

☐ Spinal Pain
- ☐ Cervical
- ☐ Thoracic
- ☐ Lumbar

☐ Joint Pain
- ☐ Knee
- ☐ Shoulder
- ☐ Other

☐ Cancer Pain

☐ Neuropathic Pain

☐ Other

REASON FOR VISIT:

☐ Consultation Only

☐ Consultation and Treatment (if applicable)

SPECIAL INSTRUCTIONS:

☐ Procedure / Treatment Request

☐ Other

DOCUMENTATION INCLUDED WITH REFERRAL:

☐ Office Notes ☐ Imaging Report (MRI, X-Ray, CT)

An electronic copy of this form is available on our website: www.delmarvapain.com/doctor-forms/