Commonwealth PAIN & SPINE

Please Fax Form To:
(866) MYPAIN4
697-2464

Thank you in advance for giving us the opportunity to care for your patient. Please complete the following info and fax to our attention. Our dedicated scheduling staff will contact the patient within 48 hours and notify your office of the appointment date and time via return fax.

Jason C. Lewis, M.D.
Board Certified Pain Medicine
Board Certified Anesthesiology

S. Kyle Young, M.D.
Board Certified Pain Medicine
Board Certified Anesthesiology

James Jackson, M.D.
Board Certified Pain Medicine
Board Certified Anesthesiology

Jenna Dismore, M.D.
Board Certified Pain Medicine
Board Certified Anesthesiology

Brendon Coughtry, M.D.
Board Certified Pain Medicine
Board Certified Anesthesiology

Nicolaus Winters, M.D.
Board Certified Pain Medicine
Board Certified Anesthesiology

Brandon Gish, M.D.
Board Certified Pain Medicine
Board Certified Anesthesiology

Michael J. Walls, M.D.
Board Certified Pain Medicine
Board Certified Anesthesiology

Joseph Folz, D.O.

REFERRAL

Today's Date: _____

Referring Provider: _____

Referring Provider Phone: _____

Referring Provider Fax: _____

Patient Name: _____

Patient Cell #: _____

Patient Home #: _____

Patient DOB: _____

CPA PASSPORT I.D. # 50053274

WE ACCEPT ALL MAJOR MEDICAL INSURANCE; MEDICARE & MEDICAID

AUTHORIZATION

❑ Evaluate and Treat as Appropriate ❑ Medication Management ❑ Procedure (Detail Below)

❑ Special and/or Specific Requests: _____

FOCUSED PAIN (CIRCLE ALL THAT APPLY)

HEADACHE	HEAD, NECK AND THROAT			CERVICAL SPINE	THORACIC
LUMBAR-SACRAL	SHOULDER	HIP	KNEE	MYOFASCIAL	PERIPHERAL NEUROPATHY
FIBROMYALGIA	SYMPATHETIC MEDIATED PAIN			NEUROPATHIC	POST SURGICAL CHRONIC
CANCER	PHANTOM	SHINGLES/PHN		PELVIC PAIN	CHRONIC PANCREATITIS

OTHER: _____

PREVIOUS NEURO OR ORTHO CONSULT? Y / N PROVIDER: _____

PREVIOUS PAIN MANAGEMENT? Y / N PROVIDER: _____

THE FOLLOWING DOCUMENTATION MUST BE ATTACHED

1. OFFICE NOTES, HISTORY & PHYSICAL
2. PATIENT DEMOGRAPHICS (MUST INCL. SSN, ADDRESS)
3. IMAGING
4. **COPY OF INSURANCE CARD(S)**

Our staff is unable to schedule without the above.

WORKER'S COMPENSATION CLAIMS

Date of Injury: _____ Claim #: _____

Adjustor Name & Number: _____

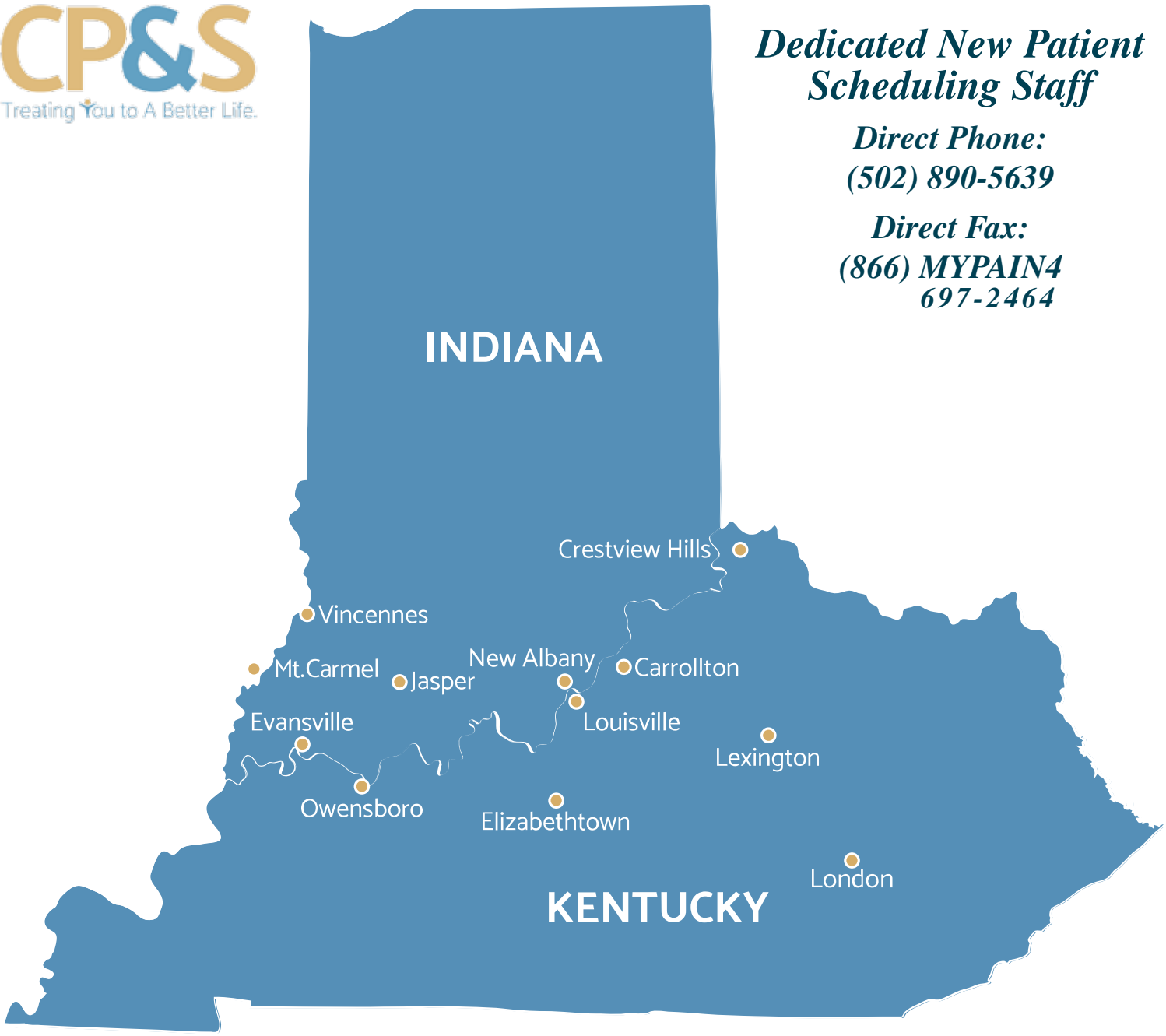
***Please attach approval for appointment.

CP&S
Treating You to A Better Life.

Dedicated New Patient Scheduling Staff

Direct Phone:
(502) 890-5639

Direct Fax:
(866) MYPAIN4
697-2464



LOUISVILLE
120 Executive Park
Louisville, KY 40207
Office 502-855-7200

LEXINGTON
101 Prosperous Place, Ste 300
Lexington, KY 40509
Office 859-275-5229

ELIZABETHTOWN
1107 Crown Pointe Drive, Ste 107
Elizabethtown, KY 42701
Office 270-506-3300

JASPER
1025 First Avenue
Jasper, IN 47546
Office 812-476-7111

NEW ALBANY
3602 Northgate Court, Ste 39
New Albany, IN 47150
Office 812-670-5684

EVANSVILLE
7145 E. Virginia Street, Ste 5000
Evansville, IN 47715
Office 812-476-7111

CRESTVIEW HILLS
320 Thomas More Pkwy, Ste 202
Crestview, KY 41017
Office 859-331-0432

MT. CARMEL
1418 College Drive
Mt. Carmel, IL 62863
Office 618-240-2740 opt #2

OWENSBORO
2200 E. Parrish Avenue, Bldg A
Owensboro, KY 42303
Office 812-476-7111

CARROLLTON
309 Eleventh Street
Carrollton, KY 41008
Office 502-855-7200

LONDON
100 London Mountain View Dr
London, KY 40721
Office 859-275-5229

VINCENNES
520 South 7th Street
Vincennes, IN 47591
Office 812-962-7890

MyPainSolution.com