Advanced Pain Treatment Center
INNOVATIVE HELP FOR MANAGING YOUR PAIN

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REFERRAL FORM

Please complete the information below and fax to our office at 859-331-4163 or 513-492-9325. After reviewing the information we will contact your office and the patient.

Patient Name: _____ Date Of Birth: _____
Home Phone: _____ Alt Phone: _____
Address: _____
Referring Provider: _____ Primary Care Provider: _____
Symptoms/Diagnosis: _____
Primary Insurance and ID#: _____
Secondary Insurance and ID#: _____

Patient prefers to be seen at the: _____ Mason Location _____ Edgewood Location

Check One: Is this referral for ____ Evaluation & Management OR ____ Only Evaluation?

Is precertification or prior authorization required? YES / NO
If Yes, list precertification or prior authorization # _____

If available and applicable please fax the following items along with this referral form:

- MRI
- CT Scan
- Myelogram
- X-Ray of spine
- EMG & NCS
- Operation Notes

Please have the patient bring films and/or cd of MRIs, CT scans and X-rays to their first appointment.

If your need is urgent please call 859-331-4159 or 513-492-9317.

Thank you for your referral.

Office Use Only:
Patient Scheduled: _____ Patient Notified: _____
Referring Provider Notified and Contact Info Confirmed: _____

EDGEWOOD OFFICE: 162 Barnwood Drive, Edgewood, KY 41017
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MASON OFFICE: 6406 Thornberry Court, Unit 220A, Mason, OH 45040
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