REFERRAL FORM

Advanced Pain Treatment Center
INNOVATIVE HELP FOR MANAGING YOUR PAIN

162 BARNWOOD DRIVE, EDGEWOOD, KY 41017

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********A TRUE MULTIDISCIPLINARY PAIN TREATMENT CENTER********

WE HAVE INHOUSE BEHAVIORAL THERAPIST, MEDICAL EXERCISE, & MASSAGE THERAPIST SPECIFICALLY FOR PAIN PATIENTS

Patient Name:_____DOB: _____

Home Telephone #_____Alt #_____

Referring Physician: _____

Symptoms / Diagnosis: _____

Insurance Type:

Primary: _____

Secondary: _____

IS PRE-CERTIFICATION OR PREAUTHORIZATION NEEDED? YES / NO

IF YES, PLEASE GIVE THE PRE-AUTHORIZATION OR PRECERT #_____

PLEASE CHECK ONE:

Is this referral for ☐ Evaluation & Management OR ☐Only Evaluation?

- IF AVAILABLE, PLEASE FAX THE REPORT OF THE FOLLOWING TO THE CENTER

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

- ON THE DAY OF EVALUATION, PLEASE HAVE THE PATIENT BRING THE FILMS OR THE CD ROM OF THE MRI, CT SCAN OR X-RAY OF THE SYMPTOMATIC PART.

- IF AVAILABLE, PLEASE FAX RELEVANT OPERATION or PROCEDURE NOTES.

PLEASE FAX THIS COMPLETED FORM TO: 859-331-4163 or E MAIL to info@aptcmd.com

PLEASE CALL 859-331-4159 IF YOU HAVE ANY QUESTION

OtriMed
Measuring health from lab to life

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THANK YOU FOR YOUR REFERRAL!!