The Clinic of Richard A. Evans, MD

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REFERRAL FOR CONSULTATION

DATE: _________________ Number of Pages Faxed:___________

PATIENT INFO:

Patient Name:____ Phone: _____________________

Is this a work-related injury? _________yes ___________no

Has the patient been seen in any Pain Clinic before? _____ yes ______no

If yes, Facility name: ____

To the best of your knowledge, has this patient ever been dismissed by another physician?

_______ yes _______ no

If yes, the Physician's name: ____

Patient's Primary Care Physician: ____

DX: ____

____

____

Reports Needed for Referral For Consultation to Doctors Pain Clinic:

____Initial H & P

____Any summarizing note, e.g., Hospital Discharge Summary

____Last two Progress Notes

____Demographic Form

____C-9 for Worker's Compensation

____Medication List

____Attach previous or recent test reports/results related to the condition
(MRI, X-RAYs, CT Scans, EMGs, etc.)

We will call your patient to schedule an appointment as soon as all the information above is received in our office.

REFERRING PHYSICIAN INFO:

Physician Name:____

Office Contact for this Referral:____Ext________________

Phone ____________________________ Fax ___________________________

Address ____

City__________________________State_____________Zip_______________

NPI# ____________________________Medicaid Billing Number: _______________________________

UPIN#_________________________