

CAROLINAS PAIN INSTITUTE, P.A.

145 Kimel Park, Suite 330 Winston-Salem, NC 27103

Phone 336-765-6181 Fax 336-714-8396

REFERRAL INTAKE FORM

In anticipation of your referral, thank you for taking the time to fill out this form. It will greatly facilitate being able to see your patient in a timely manner.

If you will fax the completed form to us at 336-714-8396, ATTENTION: Appointment Needed- we will call the patient with the appointment. Feel free to call with any questions. Please complete this form as much as possible to avoid delays in scheduling your patient. Thank you for your help.

INCLUDE OFFICE NOTES, RADIOLOGY REPORTS, COPY OF INSURANCE CARD IN FAX

Patient Name _____ Phone _____

Cell Number: _____

Address _____

City: _____ State: _____ Zip: _____

DOB _____ SS# _____ Ok to leave message at home re: appts? (Y or N)

Emergency Contact _____ Phone _____

CIRCLE ONE: M F (gender) Spouse Name: _____

Patient's Employer _____ Phone _____

Attach a copy of front and back of insurance card

*Primary Insurance Co Name: _____

Insurance Address: _____

* Is patient the policyholder? (Y or N) If not, who is? _____

Certificate# _____ Group # _____

*Secondary Insurance Co Name: _____

Insurance Address: _____

* Is patient the policyholder? (Y or N) If not, who is? _____

Certificate # _____ Group # _____

*Name of Worker's Comp Company _____

Contact Person _____ Phone _____

Address _____

Claim Number: _____ Approved: Yes No

Referring MD _____ UPN # _____ Office Contact Person _____

Fax _____

Phone _____ Ext. _____ Address: _____

Diagnosis _____ Date Onset of Pain _____

Procedure Requested _____

Primary Care Physician _____

Is patient Diabetic? (Y or N) Medicine(s) used to control Diabetes _____

Is patient taking a blood thinner (Coumadin, Heparin, Plavix, Ticlid)? Yes or No

If so, which one(s) _____ Last PT/PTT (date and results) _____

Prescribing Physician for Blood Thinner _____

Date of last MRI _____ (Please fax this report with the office notes.)

Is patient approved for only a limited number of visits or a limited period of time? (Y or N)

How many visits and/or for how long? _____

Please note the approval number _____

For CPI use only:
Patient to see Dr. _____ APPROVED: _____
Employee's name/date of referral _____ / _____