Carolinas Pain Institute, PA
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Fax (336) 714-8380
Physician Direct Line: 336-714-6454
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PATIENT REFERRAL FORM – WINSTON-SALEM

Please choose from one of the following options:

__ **Dr. Christopher Gilmore** __ **Dr. Leonardo Kapural**

OR FIRST AVAILABLE

1. Patient Demographic Information

Patient name: _____
Street address: _____
City: _____ State: _____ Zip: _____

Phone number: _____ Alternate phone number: _____
DOB: _____ SSN: _____

Patient's employer: _____
Patient's primary care physician: _____
Patient's Primary Insurance: _____
Patient's Secondary Insurance (if any): _____

2. Referring Provider

Referring physician: _____
Office address, city, state, zip code: _____
Office phone number:_____ Fax: _____
Office contact person: _____

3. Referral Criteria

What service would you like us to provide to your patient? Please check one:

__ Consideration for the following procedure:
__ Consultation with recommendations made for pain management
__ Evaluate and assume responsibility for pain management

4. Medical Imaging and required documents:

Please fax this completed form to the fax number listed above, along with:

__ Copy of patient's insurance card(s) **(Front and back copy is required before referral is reviewed)**
__ Copies of 2-3 most recent office notes
__ Copies of any X-ray/MRI/CT reports relating to the patient's pain symptoms

*Once received, please allow up to **10 business days** for our physicians to review. Once approved, our staff will contact the patient directly to schedule an appointment. If we are not able to provide services to your patient, a staff member will notify your office as soon as possible. Thank you!*

Additional Questions? Please contact NP REFERRAL COORDINATOR 336-765-6181 ext 133/ext 288