



# Medical Pain Management SERVICES, LTD

## Facsimile Consultation Form

fax 815.229.0050

phone 815.397.8400

Date \_\_\_\_\_ Physician Request \_\_\_\_\_

Physician Requesting Consultation \_\_\_\_\_

Phone \_\_\_\_\_ Fax # \_\_\_\_\_

Reason For Consultation / Referral \_\_\_\_\_

### Patient Information

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State & Zip \_\_\_\_\_

Home # \_\_\_\_\_ Cell # \_\_\_\_\_ Work # \_\_\_\_\_

SSN # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Birth Date \_\_\_\_\_

Primary M.D. \_\_\_\_\_ Phone \_\_\_\_\_

### Insurance Information

**\*\*\* Please include copy of insurance card (front & back) \*\*\***

Group Insurance \_\_\_\_\_ Employer \_\_\_\_\_

Policy Holder Name \_\_\_\_\_ DOB \_\_\_\_\_ ID # \_\_\_\_\_

Work Comp / MVA Ins \_\_\_\_\_ Phone \_\_\_\_\_

DOI: \_\_\_\_\_ Atty and or Adjustor Name & Phone \_\_\_\_\_

**\*\*\* MVA CLAIM - PLEASE INCLUDE COPY OF INDIVIDUAL'S INS INFO ALSO \*\*\***

### Current Testing & Medical Records

**Attach Copy of Report**

MRI/X-Ray    No    Yes    Date \_\_\_\_\_    Location \_\_\_\_\_

CT Scan    No    Yes    Date \_\_\_\_\_    Location \_\_\_\_\_

EMG    No    Yes    Date \_\_\_\_\_    Location \_\_\_\_\_

**Is the patient taking COUMADIN or other blood thinners?**    No    Yes

**Is the patient allergic to any Medications? If YES, what?** \_\_\_\_\_

**Is the patient diabetic?**    No    Yes    Insulin    Diet

**Please complete this form in its entirety and include: Office Notes / Dictation, Insurance Information, Med List, MRI and/or X-Ray Reports to process referral in a timely manner.**

*~ Thank You*