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NEW PATIENT REFERRAL FORM

Consulting/Referring Physician: _____ Office Fax: _____

Contact Person at Your Office: _____ Contact Tele: _____

Patient Name: _____ Date of Birth: _____

Patient Phone: _____ Alt. Tele: _____

Primary Ins: _____ Secondary Ins: _____

Does patient have workers compensation? ❑ Yes ❑ No

If yes, does patient have attorney? ❑ Yes ❑ No – If yes, Attorney Name: _____

ALL WORKERS COMPENSATION REFERRALS MUST BE SUBMITTED WITH A 1010 APPROVAL AND CORRECT ADJUSTER INFORMATION. IF APPROVAL IS NOT SUBMITTED, THE REFERRAL PROCESS WILL BE DELAYED.

Is this condition a result of an automobile accident? ❑ Yes ❑ No

If yes, is there a liability claim? ❑ Yes ❑ No – If yes, Attorney Name: _____

Is patient currently being treated by a pain management physician? ❑ Yes ❑ No

If yes, what doctor? _____

Reason for physician change? _____

Has patient had surgery on the spine? ❑ Yes ❑ No

Has patient had a MRI/X-ray? ❑ Yes ❑ No

Reason for Consult/Referral (including ICD-10 code): _____

_____

PLEASE FAX ALL ITEMS TO PREVENT DELAY IN SCHEDULING:

1. **PATIENT DEMOGRAPHICS FORM – PLEASE DO NOT SEND SCREENSHOTS**
2. **INSURANCE INFO, WORKERS COMP INFO, ATTORNEY INFO**
3. **LAST OFFICE VISIT NOTE(S) AND OTHER RELATED DOCUMENTS**
4. **MEDICATION SUMMARY, INCLUDING CURRENT OR PRIOR NARCOTICS**
5. **MRI, X-RAY, CT, OR OTHER IMAGING REPORTS (IF AVAILABLE)**

FIND MORE INFORMATION ON OUR WEBSITE:

WWW.ARKLATEXSPINE.COM