# Eastern Regional Pain Specialists Referral Form

**From:** Referring Physician: _____
Contact Person: _____
Address: _____
Phone and Fax: _____

**Patient Information:**
Patients Name: _____ DOB: ___/___/___
Insured's Name: _____ SSN: ___-___-____
Phone: (h) _____ (w) _____
Street Address: _____
City/State/Zip: _____
Email: _____
Diagnosis: _____ ICD-10: _____
Reason for Referral/ Hx & PE: _____
_____
_____

**Insurance Information-please attach copy of insurance card**
Health Plan: _____ Product Type: _____
Medical Group: _____ Auth. #: _____
# visits: _____ Effective Dates: _____ to _____ ID #: _____
Services Authorized: _____

**Checklist:**
___patient information sheet (demographics)
____ copy of insurance card(s)
____ pertinent medical records
____ imaging related to referral

_____

*To be completed by Eastern Regional Pain Specialists Staff*
**Referral confirmation:**
Referral Accepted? ___ Yes ___ No
Appointment Scheduled with: _____ Date & Time: _____
___Patient refused scheduling ___Patient prefers to contact specialist to schedule at later date
Request for additional supporting clinical information (please detail): _____
_____
Person Completing confirmation: _____ Date: _____