ADVANCED PAIN MEDICINE, PSC
101 PROPEROUS PLACE, SUITE 300
LEXINGTON, KY 40509

For Appointments Fax this Referral Form to (859) 271-0220
Any Questions Call (859)-271-3114

REFERRING PHYSICIAN INFORMATION
Must be filled out completely with all required information

Referring Physician: ______________________________

Address: ______________________________
Street Address City State Zip Code

Contact Name: ______________________________

Phone Number: ____________________ **Fax Number**: ____________________

Physician NPI# ____________ **UPIN #** ____________ **KENPAC #** ____________

□ **Saroj Dubal, MD, DABPM** □ **Donald Douglas, MD, CIME** □ **David Moore, PA-C**

Evaluation Only: ____________________ **Evaluation and Treat**: ____________________

Diagnosis: ______________________________

****PATIENT INFORMATION****

PATIENT: ______________________________ **SSN**: ____________________

DOB: ____________ **HOME PHONE**: ____________ **CELL PHONE**: ____________

ADDRESS: ______________________________
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****INSURANCE INFORMATION****

PRIMARY INSURANCE: ______________________________

SECONDARY INSURANCE: ______________________________

WORK COMP OR AUTO INSURANCE: ______________________________

ADDRESS: ______________________________

DATE OF INJURY: ____________________ **CLAIM #** ____________________

CLAIM ADJUSTOR: ____________________ **EXTENTION**: ____________

TELEPHONE: ____________________ **FAX**: ____________________

Please fill out form completely with all required information and fax a copy of patient's office notes as well as a copy of the insurance card(s) to 859-271-0220. If this is a workman's compensation appointment, you will need to call the insurance adjustor and get a new patient evaluation approved. If the patient will need an injection the day of the evaluation, it must be approved in advance.

*****PLEASE MAKE COPIES OF THIS FORM FOR FUTURE REFERRALS***** ***02-20-12 APM***