

FAX REFERRAL FORM

Fax 1-248-735-7331
Ph 248-735-8272
www.tricountypain.com

TCPC
TRI-COUNTY PAIN CONSULTANTS, PC

Please fax this form, along with appropriate patient medical information to our central scheduling location at TCPC.
We will call your patient to schedule an initial consult in the first available appointment and will notify you of the appointment details.

Date: _____ Patient Name: _____
Social Security No: _____ Date of Birth: _____ Home Phone No: _____
Referring Physician: _____ Phone No: _____ Fax No: _____
Referring Office Contact: _____ PCP (if not referring Dr): _____
PCP Phone No: _____

☐ **Demographics are included with this fax**

☐ **Copy of insurance card is included with this fax**

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Spouse's Name: _____
Patient Address: _____
Employer: _____
Is this Work or Auto related? ☐ No ☐ Yes, if yes, please provide the Claim No: _____
Date of Injury: _____ Insurance Carrier: _____
Adjuster Name: _____ Phone No: _____
Primary Insurance: _____
Contract No: _____ Insured Name: _____
Group No: _____ Employer: _____
Secondary Insurance: _____
Contract No: _____ Insured Name: _____
Group No: _____ Employer: _____

Reason for Referral:

- | | | |
|---|---|---|
| <input type="checkbox"/> Injection Therapy | <input type="checkbox"/> Discogram | <input type="checkbox"/> Platelet Rich Plasma Therapy (PRP) |
| <input type="checkbox"/> Evaluate and Treat | <input type="checkbox"/> Medication Treatment Plan | <input type="checkbox"/> Post Surgical Complications |
| <input type="checkbox"/> Kyphoplasty | <input type="checkbox"/> Spinal Cord Stimulator Trial | |

Provider:

- ☐ First Available ☐ Wisam George, DO

Diagnosis: _____

Records: In order to schedule your patient, please send the following records with your referral:

(Please note, if applicable records have not been received, the patients appointment may be delayed)

- | | |
|---|-------------------------------|
| <input type="checkbox"/> Previous pain management records..... | <input type="checkbox"/> None |
| <input type="checkbox"/> Most recent imaging related to diagnosis..... | <input type="checkbox"/> None |
| <input type="checkbox"/> Current medication list..... | <input type="checkbox"/> None |
| <input type="checkbox"/> Most recent chart notes related to diagnosis..... | <input type="checkbox"/> None |
| <input type="checkbox"/> Initial evaluation and discharge summary for previous physical therapy related to diagnosis..... | <input type="checkbox"/> None |

If you are receiving transmission errors or have questions, please call 248-735-8272.