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: _____
_____

****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*