ADVANTAGE
SPINE AND PAIN CARE

REFERRAL FORM

Patient Name: _____ Male / Female D.O.B. _____

Best Contact Telephone: _____

Insurance: _____ Subscriber ID/Claim #:_____

Insurance /Claim Manager Phone#: _____ Claim Manager Name: _____

Pain Diagnosis/Location(s): _____

In order to expedite patient scheduling, kindly fax all of the following information:
(Please contact us at 913-685-1200 with any questions)

- ○ This completed **referral form**.
- ○ Legible copies of patient's **insurance card(s)** (Both sides)
- ○ All **progress and procedure notes** (past 6 months) pertaining to the above diagnosis
- ○ List of all **current medications**
- ○ Any recent pertinent **labs/testing/radiology reports** **(☐ Check if NONE IN PAST YEAR)**

REFERRING PROVIDER INFORMATION:

Name: _____

Address: _____

Phone #:_____ Fax #:_____

NPI #: _____

PROVIDER SIGNATURE: _____

TYPE OF CONSULTATION REQUESTED:

- ☐ Pain Consultation and Treatment
- ☐ Pain Consultation Only (Medical opinion/Recommendations)
- ☐ Specific Procedure Request (Scheduled separately, after initial consultation office visit)
  - ☐ Epidural Injection / Selective Nerve Root Block
  - ☐ Facet Joint Block / Medial Branch Block / RF Ablation
  - ☐ Vertebroplasty / Kyphoplasty
  - ☐ Discography
  - ☐ EMG/Nerve Conduction Study: _____
  - ☐ Other: _____

Note: In order to ensure that we prescribe safely and responsibly, we cannot guarantee assumption of medication management at the initial visit. Please contact us in advance if you anticipate special medication requirements.

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