PAIN PROGRAM

2001 Errecart Blvd Elko, NV 89801

Phone: 775-748-2195 Fax: 775-748-2197

REFERRAL FORM

Referring Physician:_____________________________________Date:_____________________________

Patient Name: ____Date of Birth: ______________________

Address____City______________________State________

Home Phone__________________________ Cell Phone___________________________

SS #________________________

Insurance Provider: ____

[ ] **CONSULT** – Expectation: Referring physician will receive a diagnosis or confirmation of a diagnosis and the doctor will suggest a treatment plan. The initial consult findings will be faxed to your office.

[ ] **CONSULT AND TREAT** – Expectation: Diagnosis, treatment plan, and treatment for painful condition(s). Consult findings, treatments, and procedure notes will be faxed to your office.

Please include the following information when faxing this referral form to the program:

[ ] History and physical (required)
[ ] Last visit note / progress note (required)
[ ] Copy of radiology reports (MRI, CT)

We will contact the patient as soon as possible.