michigan SPINE&PAIN
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FAX to: (989) 773-6279
www.michiganspineandpain.com
1-800-586-7992

REFERRAL FORM

Please fax this form, along with appropriate patient medical information, to our central scheduling location. We will call your patient to schedule an initial consultation and will notify you of the appointment date.

Thank you for allowing us to participate in your patient's care.

Date: _____ **Locations:** *Please check* ( ) Mount Pleasant ( ) West Bloomfield

Referring Provider Information: *(required)*

Referring Physician: _____

Office #: _____ Fax #: _____

Address: _____

City: _____ State: _____ Zip: _____

State License#: _____ NPI: _____

Patient Information: *(required)*

Patient Name: _____

Date of Birth: ___/____/___ SS#: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Cell #: _____

Auto / Workmen's Comp Information: *(required)*

Is this Work or Auto related? ( ) No ( ) Yes
If yes, please provide the claim information

Injury Date: __/___/___Claim#:_____

Carrier: _____

Adjuster Name: _____

Adjuster Phone #: _____

Attorney Name: _____

Type of Auto Medical Benefits:

☐ Primary (Auto Insurance pays first for medical)
☐ Coordinated (Health Insurance is billed first)

Insurance Information: *(required)*

Primary Insurance: _____

Insured ID #: _____ Group #: _____

( ) Spouse ( ) Self ( ) Dependent

Subscribers Name: _____

Date of Birth: ___/___/____ SS#: _____

Secondary Insurance: _____

Insured ID #: _____ Group #: _____

( ) Spouse ( ) Self ( ) Dependent

Subscribers Name: _____

Date of Birth: ___/___/____ SS#: _____

Reason for Referral: _____

☐Evaluate and Treat ☐Injection Therapy ☐Chiropractic ☐Laser Therapy

☐EMG Consult ☐Physical Therapy ☐Acupuncture ☐Non-Surgical Spinal Decompression (DRX 9000)

In order to schedule your patient, please send the following records with your referral:
Please note, if applicable records have not been received, the patient's appointment may be delayed)

- Last two office notes ..... ☐None
- Most recent imaging related to diagnosis..... ☐None
- Previous pain management records..... ☐None
- Initial evaluation and discharge summary for previous physical therapy related to diagnosis..... ☐None