Grand Rapids Pain

Please complete this form and fax it to 866.493.3535. We will schedule with the patient and let you know when the appointment has been set. Thank you for the referral.

Date* _____

Patient Name* _____

Last 4 of SSN* _____

Date of Birth* _____

Patient Home Phone* _____

Referring Physician* _____

NPI # (If 1st Referral)* _____

Referring Office Contact* _____

Office Address _____

_____

Phone* _____ Fax* _____

PCP (If Not Referring Dr)* _____

Phone* _____ 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 _____

Primary Insurance* _____

Contract No.* _____ Insured Name* _____

Group No.* _____ DOB _____

Secondary Insurance* _____

Contract No.* _____ Insured Name* _____

Group No.* _____ DOB _____

Reason for Referral* _____

_____

☐ Evaluate Only

☐ Evaluate and Treat

☐ Diagnostic Nerve Block Only _____ (type)

☐ Other _____ (type)

Previous Studies/Treatments and Location where performed.
Please include all diagnostics, medication lists, and OV notes that pertain to referral.

☐ X-Ray	When	_____	Where	_____
☐ CT Scan	When	_____	Where	_____
☐ MRI	When	_____	Where	_____
☐ Discogram	When	_____	Where	_____
☐ Other	When	_____	Where	_____
☐ Pain Management*	Who	_____	Where	_____

**Indicates required information*

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