FAX REFERRAL FORM

Fax Completed Referral Form to: (260)353-1447 – Office Phone (260)353-1444

Dr. Firas Kara
United Interventional Pain Center
7233 W Jefferson Blvd.
Fort Wayne, IN 46804

Date: _________________

Patient Name: _____________________________________ Date of Birth: _________________

Address: ____

Phone Number: ________-________-________ Social Security #_______________________

Insurance: ____

Patient's Area of Pain: ____

Patient's Diagnosis: ____

Has Patient Tried Physical Therapy? Yes/No

Opiate Use
Please circle one of the following:

* Please refrain from opiate prescription *Prescribe opiates at your discretion

Please Fax the following information along with this form to: (260)353-1447

- Recent Dictation or Office Notes
- MRI/X-Ray Reports
- Insurance Card (front and back)

Referring Physician Name/Office: ____

Return Phone # __________________________ Return Fax # ___________________________

- For any questions please contact our office, we will contact your patient within 1-3 days of receiving this fax.

Confidentiality Notice:
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