REFERRAL WORKSHEET

GOSHEN PHYSICIANS PAIN MANAGEMENT

Located at Goshen Orthopedics & Sports Medicine
1824 Dochester Court, Ste A, Goshen, IN 46526
Kacy Davis, NP
Ph: 574-534-2548 Fax: 574-534-3622

PHYSICIAN REFERRING____ **TODAYS DATE:**__________________
Address (if not in our file): ___________________________________City________________ State___ Zip________
Phone____Fax____

Please check only one
( ) Please **EVALUATE** patient for further treatment options.
( ) Please **EVALUATE AND TREAT** the patient for possible _________________________________, but have patient's long term follow up with our office.
( ) Please **EVALUATE THE PATIENT AS A 2ND OPINION** and they are to return to our office.

Diagnosis:_____________________________________ **Physician Signature:**________________________________

Patient Information

Name___________________________**Ph #**_______________**DOB:**______________**SS#**_______________________

****Please send demographics and insurance information separately****
Comments or Special Request

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We are sending the following to the Pain Clinic:

- ❑ Relevant office notes, medication lists, other documents that may help with treatment **(this is the bare minimum requested).**
- ❑ MRI of the____
- ❑ CT SCAN of the _______________________________________
- ❑ X-RAYS of the ____
- ❑ EMG of the____
- ❑ MYELOGRAM of the__________________________________

PLEASE FAX US THE REFERRAL SHEET AND WE WILL CALL THE PATIENT.

The hours of the Pain Clinic are: Monday through Friday 8:00 AM – 4:00 PM