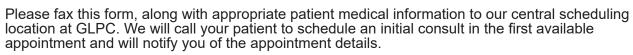
FAX REFERRAL FORM (800) 940-9601

www.greatlakespain.com





| Date: | | Patient Name:_ | | | |
|--|------------------------|--------------------------------------|----------------------------|-------------------------|---------|
| Social Security No: | | Date of Birth: | | Home Phone No: | |
| Referring Physician: | | Phone No: | | - Fax No: | |
| Referring Office Contact: | | PCP (if not refe | PCP (if not referring Dr): | | |
| PCP Phone No: | | | | | |
| ☐ Demographics are inc | cluded with this fax | □ Сору | y of insurance | card is included with t | his fax |
| Marital Status: ☐ Single | e □ Married □ □ | Divorced □ Widow | ed Spouse's | Name: | |
| Patient Address: | | | | | |
| Employer: | | | | | |
| Is this Work or Auto relate | ed? □ No □ Yes, if y | yes, please provide t | the Claim No: _ | | |
| Date of Injury: | Insurance Car | Insurance Carrier: | | | |
| Adjuster Name: | Phone No: | Phone No: | | | |
| Primary Insurance: | | | | | |
| Contract No: | | Insured Name: | : | | |
| Group No: | Employer: | Employer: | | | |
| Secondary Insurance: _ | | | | | |
| Contract No: | | Insured Name: | : | | |
| Group No: | Employer: | Employer: | | | |
| Reason for Referral: | | | | | |
| ☐ Injection Therapy | | ☐ Platelet Rich Plasma Therapy (PRP) | | | |
| ☐ Evaluate and Treat | reatment Plan | | | | |
| ☐ Kyphoplasty | ☐ Spinal Cord S | | 3 | • | |
| Provider: First Ava | | | oreen Toner. MS | SN. RN-BC. AG-NP | |
| | | <i>J</i> , | , | , -, - | |
| Diagnosis: | | | | | |
| | | | | | |
| Records - In order to scho | edule vour natient inl | ease send the follow | vina records wit | h vour referral: | |
| (Please note, if applicable re | | | • | • | |
| □ Previous pain management records | | | | | None |
| ☐ Most recent imaging r | | | | None | |
| □ Current medication list | | | | | None |
| ☐ Most recent chart notes related to diagnosis | | | | | None |
| □ Initial evaluation and discharge summary for previous physical therapy related to diagnosis□ | | | | | None |