FAX REFERRAL FORM

(800) 940-9601

www.greatlakespain.com

Please fax this form, along with appropriate patient medical information to our central scheduling location at GLPC. We will call your patient to schedule an initial consult in the first available appointment and will notify you of the appointment details.

Date: ______________________ Patient Name: ______________________

Social Security No: ______________________ Date of Birth: __________ Home Phone No: __________

Referring Physician: ______________________ Phone No: __________ Fax No: __________

Referring Office Contact: ______________________ PCP (if not referring Dr): ______________________

PCP Phone No: ______________________

☐ **Demographics are included with this fax** ☐ **Copy of insurance card is included with this 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 No: ______________________

Primary Insurance: ______________________

Contract No: ______________________ Insured Name: ______________________

Group No: ______________________ Employer: ______________________

Secondary Insurance: ______________________

Contract No: ______________________ Insured Name: ______________________

Group No: ______________________ Employer: ______________________

Reason for Referral:

☐ Injection Therapy ☐ Discogram ☐ Platelet Rich Plasma Therapy (PRP)

☐ Evaluate and Treat ☐ Medication Treatment Plan ☐ Post Surgical Complications

☐ Kyphoplasty ☐ Spinal Cord Stimulator Trial

Provider: ☐ First Available ☐ Erik Voogd, MD ☐ Doreen Toner, MSN, RN-BC, AG-NP

Diagnosis: ______________________

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

☐ Previous pain management records.......................................☐ None

☐ Most recent imaging related to diagnosis.......................................☐ 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

*If you are receiving transmission errors or have questions, please call (**269) 266-3104.***