Elite
PAIN MANAGEMENT
AND RECOVERY CENTERS

REFERRAL FORM

FAX: 417-888-0189

REASON FOR REFERRAL

- ☐ Chronic Pain Management
- ☐ Opioid Use Disorder Management (Medically Assisted Therapy)
- ☐ Alcohol Use Disorder Management
- ☐ Interventional Pain Procedure

PATIENT INFORMATION

Last Name _____ First _____ Middle _____

Date of Birth _____

Address _____

Phone _____ Additional Phone _____

PROVIDER INFORMATION

Referring Physician _____ Specialty _____

Insurance Company Name _____ ID/Policy # _____

Group Code _____ Effective Date _____ Phone _____

Address _____ Fax _____

Select Your Preferred Location

☐ Springfield, MO ☐ Galena, KS

Referring Physician Signature _____ Date _____

PLEASE FAX THE FOLLOWING TO OUR OFFICE AT 417-888-0189

- ☐ Referral from primary care provider
- ☐ Medical records (including all images: X-ray, CT, MRI)
- ☐ Current medication list
- ☐ Patient insurance cards (front and back)

222 E. Primrose, Ste. E
Springfield, MO 65807
P: 417-888-0167

1601 Kansas 66, Ste. C
Galena, KS 66739
P: 316-500-3180

For additional referral forms, please visit our website at elitepainmanagement.md