REFERRAL FORM

FAX: 417-888-0189

REASON FOR REFERRAL

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

PATIENT INFORMATION

Last Name ____________ First ____________ Middle ____________

Date of Birth ____________ Address ____________

Phone ____________ Additional Phone ____________

Has patient been previously dismissed from a pain management clinic? If yes, please explain. YES / NO

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TO AVOID A DELAY IN SCHEDULING, PLEASE FAX THE FOLLOWING TO OUR OFFICE AT 417-888-0189.

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

PROVIDER INFORMATION

Referring Physician ____________ Specialty ____________

Phone ____________ Fax ____________

Address ____________

Point of Contact ____________ Phone ____________

PREFERRED LOCATION

- ☐ Springfield, MO
- ☐ Myrtle Beach, SC

Referring Physician Signature ____________ Date ____________

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

8212 Devon Court
Myrtle Beach, SC 29572
P: 843-273-0376

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