COFFEE REGIONAL MEDICAL CENTER

PAIN CLINIC REFERRAL FORM

1PAIN

(We do INJECTIONS ONLY)

Phone: (912) 384−1900 ext 4386 FAX: (912) 383−5663

From (Office personnel): _____

Phone #: _____ Fax: _____

Referred by Dr: _____

Patient Name: _____

Social Security #: _____

Home Phone #: _____ Work #: _____

Other Phone #: _____ DOB: _____

THIS SECTION MUST BE COMPLETED PRIOR TO REFERRAL BEING SCHEDULED

********* MRI report of lumbar spine for LESI referrals *********
********* Last office note with history and physical *********
********* Any additional information pertinent to procedure *********

Insurance Co Name: _____ Policy #: _____

Pre−cert #: _____ No pre−cert needed per: _____

Workman's comp approved per: _____ Phone #: _____

Diagnosis: _____ Procedure Requested: _____

ICD10: _____ CPT Code: _____

Physician Signature: _____ Date/Time _____

Appointment date: _____@_____A.M. / P.M.

Patient notified on: _____by_____

Physician Offices−
For the most updated form please visit
www.coffeeregional.org and
print from the "For Our Physicians" link.

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