Interventional
PAIN CARE, LLC

Thank you for referring your patient to The Pain Management Center. Please complete and fax this form. We need all of this information to accept any referral from your office.

1. Patient demographics
2. Enlarged copy of insurance cards (front and back)
3. Doctor's notes / recent office visit indicating diagnosis of pain syndrome
4. X-ray reports: routine films, CT scan and MRI (patient to bring MRI films not done in Muncie area).
5. Other reports as appropriate: EMG, lab, consulting physician documentation.

Referral Date: _____

Referring Physician: _____

Patient's PCP: _____

Physician's Phone #: _____

Physician's Fax #:_____

**PATIENT'S NAME: _____DOB:_____**

**PATIENT'S ADDRESS: _____ CITY: _____**

**STATE: _____ZIP CODE: _____**

**PATIENT'S PHONE NUMBER**: _____

Patient's Email Address (optional) _____

**DIAGNOSIS: _____**

Last Opioid Rx Written: _____

Last MRI date: _____ Body Part Scanned: _____

Location of Scan: BMH Img Center BCH CIO

JCH Open MRI Other: _____

_____Check if patient needs to be seen in 24-48 hours
(e.g. cancer, new compression fracture, acute injury)

**INSURANCE INFORMATION**

Worker's Comp YES_____NO_____

Case Worker_____ Phone Number: _____

Primary Insurance: _____

Member Name: _____

Member ID #:_____

Medicaid #:_____

Medicare #:_____

**PLEASE FAX ALL OF THE ABOVE INFORMATION TO (765) 747-3310.**

P.O. Box 1736 Muncie, IN 47308
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