THE NEXus PAIN CENTER of Columbus, LLC

Telephone: 706-653-7000

Fax: 706-653-7800

FAX-A-CONSULT

Date____/____/_____

Patient Name_________________________________ DOB: ______/________/______________

Referring MD________________________________ UPIN#______________________________

Phone No: (______)________-________________ Fax No: (______)________-____________

Primary Care MD_____________________________ Phone No: (______)______-____________

☐ Evaluation and Treatment ☐ Pain Management Consultation

☐ Pain Block Type of Pain Block (circle one on each line):

Cervical / Thoracic / Lumbar

Facet / Epidural / Transforaminal

☐ Spinal Cord Stimulator Trial

☐ Other: ____

Please fax the following information if available:

- A **legible** copy of the patient's insurance card(s) (**front and back**) and **demographics.**
- A copy of a **MRI and/or CT** scan performed within the last two years of the patient's affected area.
- Copies of the **H&P** and the most recent office notes.
- **Prescription** stating "refer to NEXus Pain Center" for the type of block or evaluation and treatment of the designated pain area and/or diagnosis
- If applicable, please obtain worker's compensation, Tricare Prime or HMO and POS **approval prior to making your referral.** Appointments will **NOT** be scheduled without it!! Workers compensation referrals should include insurance company, mailing address, claim numbers, adjuster, telephone number, employer, and date of injury.

Thank you for allowing our practice to participate in your patient's care!
We will call the patient and schedule the appointment.
You can expect prompt appointment confirmation via return fax.

Office Use Only: Date Received: _____/_____/______

Patient Appointment Date: ____/____/_____ Time ____________________

Information Not Received:

☐ Insurance Cards ☐ MRI/CT Scan ☐ Office Notes ☐ Prescription ☐ Precert

☐ Other: ____

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