



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 Only

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: _____