APAC
Centers for Pain Management™

Please fax this form to: (219) 226-0710
If you have any questions, please call (219) 488-0154

Patient Referral Form

Date _____

Referring Provider _____ Fax # _____

Please specifically document consultation requests in the patient's medical record. For consultation visits, we will send a complete report to the requesting provider after the patient visit.

PATIENT INFORMATION

First Name _____ Last Name _____

Patient DOB _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Hx/Diagnosis _____

Is the injury work-related? ☐ Is the injury related to a Motor Vehicle Accident (MVA)? ☐

Insurance (please include copy if available) _____

Preferred Scheduling Location: ☐ Crown Point, IN ☐ Dyer, IN ☐ Mishawaka, IN ☐ Swedish, IL ☐ First Available

Type of Pain

- ☐ Spinal Pain
  - ☐ Cervical
  - ☐ Thoracic
  - ☐ Lumbar
- ☐ Joint Pain
  - ☐ Knee
  - ☐ Shoulder
  - ☐ Other: _____
- ☐ Neuropathic Pain
- ☐ Follow-up preference
  - ☐ Follow-up with referring provider
  - ☐ Follow-up with APAC provider

Reason for Visit

_____

_____

_____

_____

_____

Special Instructions:

☐ Procedure/Treatment