

ADVANCED PAIN MEDICINE, PSC
1745 ALYSHEBA WAY SUITE 140
LEXINGTON, KY 40509

For Appointments Call: (859) 271-3114 or Fax this Referral Form to (859) 271-0220

REFERRING PHYSICIAN INFORMATION

****Must be filled out completely with all required information****

Referring Physician: _____				
Address: _____				
Street Address		City	State	Zip Code
Contact Name: _____				
Phone Number: _____		Fax Number: _____		
Physician NPI# _____	UPIN # _____	KENPAC # _____		
<input type="checkbox"/> Saroj Dubal, MD, DABPM	<input type="checkbox"/> Donald Douglas, MD, CIME	<input type="checkbox"/> David Moore, PA-C		
Evaluation Only: _____		Evaluation and Treat: _____		
Diagnosis: _____				

****PATIENT INFORMATION****

PATIENT: _____		SSN: _____
DOB: _____	HOME PHONE: _____	CELL PHONE: _____
ADDRESS: _____		

****INSURANCE INFORMATION****

PRIMARY INSURANCE: _____	
SECONDARY INSURANCE: _____	
WORK COMP OR AUTO INSURANCE: _____	
ADDRESS: _____	
DATE OF INJURY: _____	CLAIM # _____
CLAIM ADJUSTOR: _____	EXTENTION: _____
TELEPHONE: _____	FAX: _____

Please fill out form completely with all required information and fax a copy of patient's office notes to 859-271-0220 attn: Scheduling. If this is a workman's compensation appointment, you will need to call the insurance adjustor and get a new patient evaluation approved. If the patient will need an injection the day of the evaluation, it must be approved in advance.

****PLEASE MAKE COPIES OF THIS FORM FOR FUTURE REFERRALS****