PATIENT REFERRAL - WEST SIDE CLINIC

(Fax To: 812-477-7240 or 888-531-9990)

PLEASE INCLUDE OFFICE NOTES AND RADIOLOGY / DIAGNOSTIC REPORTS

REFERRING PROVIDER ________________________________ NPI # ______________________________

REFERRAL CONTACT _____________________ EMAIL ADDRESS ______________________________

DATE_____/_____/______ PHONE NUMBER ________________ FAX NUMBER ________________________

ADDRESS ________________________ CITY ____________________ ST__________ ZIP _____________

PATIENT NAME _______________________________________ EMAIL ADDRESS ______________________

PHONE NUMBER ____________________ DOB______/_______/_______ SS#_________-________- ________

ADDRESS ________________________ CITY ____________________ ST __________ ZIP _____________

REASON FOR REFERRAL ____

- ❒ EVAL & TREAT
- ❒ EVALUATE FOR SPINAL CORD STIMULATOR
- ❒ EVALUATE FOR INTRATHECAL PAIN PUMP
- ❒ SPECIFIC PROVIDER REQUESTED _______________________________________
- ❒ OTHER ____

PATIENT INSURANCE INFORMATION

(PLEASE FILL OUT OR SEND FACE SHEET)

WORKERS COMP? ❒ YES ❒ NO **APPROVED?** ❒ YES ❒ NO **AUTO?** ❒ YES ❒ NO CERT CODE/ATH __________

INSURANCE CARRIER _________________________________ PHONE NUMBER ______________________

INSURED'S NAME/RELATIONSHIP _______________________ DOB____/_____/_____ (OF POLICY HOLDER)

EMPLOYER _______________________ POLICY # ________________ GROUP # ______________________

Your email address will be used solely for the purpose of expediting scheduling. It will not be shared or published anywhere. Please email referrals@apccweb.com to report any issues with scheduling this appointment.

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