

# Metropolitan Pain Management Consultants, Inc.

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## MPMC REFERRAL FORM

Referring Doctor's Full Name: _____	Phone: _____
Address: _____	Fax: _____
City: _____ State: _____ Zip: _____	Contact: _____
License #: _____	UPIN #: _____
Date Sent: _____	
Patient Name: _____	Patient Phone #: _____
<input type="checkbox"/> Existing MPMC patient	<input type="checkbox"/> New Patient

### Patient Diagnosis and ICD – 9 Code(s)

\_\_\_\_\_  
\_\_\_\_\_

### Please indicate what service you would like MPMC to provide

- Consultation Only  Consultation and Treatment  Assume Medication Management

### Note: MPMC will not prescribe medications at the 1<sup>st</sup> visit

<input type="checkbox"/> Discography	Anatomical region
<input type="checkbox"/> Epidural Steroid Injection	<input type="checkbox"/> Cervical
<input type="checkbox"/> Facet Injection	<input type="checkbox"/> Thoracic
<input type="checkbox"/> IDET	<input type="checkbox"/> Lumbar
<input type="checkbox"/> Lumbar Sympathetic Block	<input type="checkbox"/> Level(s) _____
<input type="checkbox"/> Myobloc / Botox injection	
<input type="checkbox"/> Radio Frequency (location) _____	
<input type="checkbox"/> SI joint injection	
<input type="checkbox"/> Stellate Ganglion Block	
<input type="checkbox"/> Other: _____	

In order to expedite processing your patient's referral, ALL of the following items must be received by MPMC. If all information is not received within 30 days from the initial request, the referral will not be able to be processed and all records will be destroyed.

### **FAX to (916) 925-3985 ALL of the following information:**

1. **Face Sheet with patient information**
2. **Legible copies of the patient's insurance cards (both sides) OR,**
3. **Workers' Compensation physicians 1<sup>st</sup> report of injury**
4. **Insurance referral or prior authorization where applicable**
5. **Copies of any pertinent operative reports, diagnostic reports, progress records and X-ray film**

This information is intended only for the use of the individual or entity to which it is addressed and may contain medical information that is privileged, confidential and exempt from disclosure under applicable Federal and California law. If you are not the intended recipient, you are hereby notified that any use, dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication as an error, please notify the sender immediately by telephone (916) 568-8338 and return this communication to the sender at the above address or fax line (916) 925-3985. Once you have sent the communication to the sender please destroy the document. Thank you.