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 #: _____

☐ Existing MPMC patient ☐ 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 1st visit

☐ Discography
☐ Epidural Steroid Injection
☐ Facet Injection
☐ IDET
☐ Lumbar Sympathetic Block
☐ Myobloc / Botox injection
☐ Radio Frequency (location) _____
☐ SI joint injection
☐ Stellate Ganglion Block
☐ Other: _____

Anatomical region

☐ Cervical
☐ Thoracic
☐ Lumbar
☐ Level(s) _____

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 1st 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**