FAX REFERRAL FORM

Fax (800) 940-9601
Ph (269)-266-3104
www.southernmichiganpain.com

SMPC
SOUTHERN MICHIGAN
PAIN CONSULTANTS

Please fax this form, along with appropriate patient medical information to our central scheduling location at SMPC. We will call your patient to schedule an initial consult in the first available appointment and will notify you of the appointment details.

Date: _____ Patient Name: _____

Date of Birth: _____ Home Phone No: _____

Referring Physician: _____ Phone No: _____ Fax No: _____

Referring Office Contact: _____ PCP : _____

PCP Phone No: _____

☐ **Demographics are included with this fax** ☐ **Copy of insurance card is included with this fax**

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Spouse's Name: _____

Patient Address: _____

Employer: _____

Is this Work or Auto related? ☐ No ☐ Yes, if yes, please provide the Claim No: _____

Date of Injury: _____ Insurance Carrier: _____

Adjuster Name: _____ Phone No: _____

Primary Insurance: _____

Contract No: _____ Insured Name: _____

Group No: _____ Employer: _____

Secondary Insurance: _____

Contract No: _____ Insured Name: _____

Group No: _____ Employer: _____

Diagnosis: _____

_____

Reason for Referral:

_____

_____

Provider: ☐ First Available ☐ Matthew Kuiper, DO ☐ Barton Wild, MD

Records - In order to schedule your patient, please send the following records with your referral:
(Please note, if applicable records have not been received, the patients appointment may be delayed)

☐ Previous pain management records..... ☐ None

☐ Most recent imaging related to diagnosis..... ☐ None

☐ Current medication list..... ☐ None

☐ Most recent chart notes related to diagnosis..... ☐ None

☐ Initial evaluation and discharge summary for previous physical therapy related to diagnosis..... ☐ None

If you are receiving transmission errors or have questions, please call ***(269) 266-3104***