



PAIN MANAGEMENT SERVICES REFERRAL FORM

4515 Southlake Pkwy, Suite 200, Hoover, AL 35244

Phone 205.313.7246 Fax 205.939.1911



Date: _____

Referring Physician: _____ **Contact Person:** _____

Address _____

Phone: _____ Fax: _____

Patient Name: _____

DOB: _____ SSN _____

Home Phone: _____ Work/Cell Phone: _____

Email: _____

Pain problem being referred for: _____

Diagnosis: _____

Relevant Medical Records required:

Check each box as you attach copies to fax or email:

Ins Co: _____

Name of Insured: _____

Policy #: _____

Group #: _____

- Office Visit Notes (Treatment for pain)
- Demographic Information
- MRI and/or X-Ray reports if available
- Insurance Card

Pain Management Services:

(Note: All Interventional Procedures are image guided.)

1 1st Available R. Daniel Chang, M.D. Nitin Chhabra, M.D. Michael Gibson, MD

2 Pain Management Consult

3 Procedure Only Which procedure? _____ or TBD by the BPC M.D.

Psychological Services: Jay Heisler, Ph.D.

- Counseling/Psychotherapy:
- General/Comprehensive Psychological Evaluation
- Screening/Clearance for: _____
- Other (specify): _____

Patient Signature: _____

Date: _____