REFERRAL FAX COVER SHEET

Referral to:

Hari Prabhakar, MD, MSc
Board Certified Pain Management Specialist
Board Certified Anesthesiologist

www.aviatorpain.com
304 Insperon Drive
Grovetown, GA 30813
Phone: 706-222-4559
Fax: 706-400-6493

FROM:

DATE:

TOTAL NO. OF PAGES INCLUDING COVER:

FAX NUMBER: 706-400-6493

FAX NUMBER:

PHONE NUMBER: 706-222-4559

PHONE NUMBER:

☐ Appointment already scheduled Date: _____

☐ Please call Patient to schedule

Patient Phone: _____

CHECKLIST:

- ☐ Patient Demographics / Contact information
- ☐ Insurance cards / Billing information
- ☐ Office notes from Referring Physician
- ☐ Diagnostic reports ☐ No studies / workup done

Patient must bring Film or CD to appointment

Aviator Pain & Spine	**FAX TO** **706-400-6493** **info@aviatorpain.com**	304 Insperon Drive Grovetown, GA 30813 Phone: 706-222-4559 Fax: 706-400-6493

Pain Management Referral Form to Aviator Pain & Spine

Date

Requesting Provider NPI #

Phone # ( ) Fax # ( )

Primary Care Physician *(if different)*

Phone # ( ) Fax # ( )

Fax this form to 706-400-6493

Please include recent office visit notes and any imaging reports along with this form.

PATIENT INFORMATION

First Name Last Name

Patient DOB Phone #: ( )

Insurance Type: ☐ Comm Ins ☐ Medicare ☐ Medicaid
☐ MVA ☐ Workers Comp ☐ Self

Primary Insurance Secondary Insurance

ID or Claim #: ID or Claim #:

Adjustor: Adjustor's Phone #: ( )

Attorney: Attorney's Phone #: ( )

Date of Injury/Accident:

Other Notes / Information:

TYPE OF PAIN:

☐ Spinal Pain
- ☐ Cervical
- ☐ Thoracic
- ☐ Lumbar

☐ Joint Pain
- ☐ Knee
- ☐ Shoulder
- ☐ Other

☐ Cancer Pain

☐ Neuropathic Pain

☐ Other

REASON FOR VISIT:

☐ Consultation Only

☐ Consultation and Treatment

SPECIAL INSTRUCTIONS:

☐ Procedure / Treatment Request

☐ Other

DOCUMENTATION INCLUDED WITH REFERRAL:

☐ Office Notes ☐ Imaging Report (MRI, X-Ray, CT)

PLEASE REQUEST THAT PATIENT BRING IN CD OF ALL IMAGING IF AVAILABLE