PCA™
PAIN CARE CENTER

2845 SW Capital Ave, Suite 206
Battle Creek, MI 49015
PHONE: 269.223.7045
FAX: 269.282.0758
admin@pcabattlecreek.com

REFERRAL FORM

DATE: _____

REFERRING PROVIDER: _____ NPI # _____

PHONE NUMBER: _____ FAX # _____

PATIENT NAME (FIRST AND LAST) _____ DATE OF BIRTH _____

PATIENT HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

PATIENT'S INSURANCE _____ SUBSCRIBER ID _____

PATIENT'S PCP _____ PCP PHONE NUMBER _____

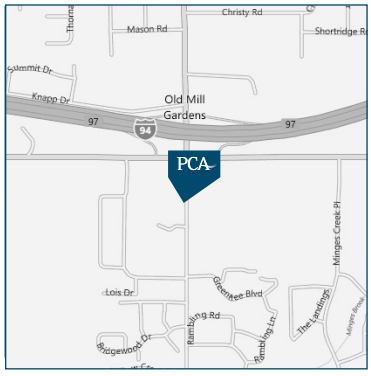
PATIENT DIAGNOSIS _____

☐ PAIN CONSULTATION (IF OPINION IS REQUESTED)
☐ PAIN CONSULTATION & TREATMENT (IF TREATMENT IS TO BE TURNED OVER)
☐ EPIDURAL INJECTION

- ☐ CERVICAL
- ☐ THORACIC
- ☐ LUMBAR
- ☐ CAUDAL
- ☐ FACET BLOCK
- ☐ JOINT INJECTION
- ☐ TRIGGER POINT INJECTION
- ☐ SYMPATHETIC BLOCKS
- ☐ BURSA INJECTIOS
- ☐ RADIOFREQUENCY RHIZOTOMY
- ☐ OCCIPITAL NEVRE BLOCKS
- ☐ MEDIAL BRANCH NERVE BLOCKS
- ☐ SELECTIVE NERVE ROOT BLOCKS (Lumbar)
- ☐ SACROILICA JOINT BLOCKS
- ☐ PERIPHERAL NERVE BLOCKS
- ☐ IMPLANTABLE DEVICES

IN ORDER TO HELP US PROVIDE YOUR PATIENT WITH THE BEST POSSIBLE CARE PLEASE FAX THE FOLLOWING:

>> COMPLETED REFERRAL FORM
>> LEGIBLE COPIES OF PATIENT'S INSURANCE CARDS (BOTH SIDES)
>> MOST RECENT CLINICAL/PROGRESS NOTE PERTAINING TO PAIN CONDITION
>> LIST OF CURRENT MEDICATIONS
>> CURRENT DIAGNOSTIC TESTING WORK-UP AND RADIOLOGY REPORTS ON PATIENT



PHYSICIAN SIGNATURE _____ DATE _____

PLEASE FAX THE FORM TO **269.282.0758**