Grand Rapids
4024 Park East Court SE,
Suite C
P: 616-975-1186
F: 616-975-0467

Big Rapids
20095 Gilbert Road,
Suite B
P: 231-592-1360
F: 231-592-1361

WEST MICHIGAN PAIN REFERRAL FORM

REQUESTED TREATMENT:

☐ SPINE CENTER OF EXCELLENCE EVALUATION

☐ EVAL AND TREAT FOR : _____

☐ EMG : (please specify extremity)_____

Has patient ever been to another pain clinic Y / N If YES we need those records faxed to 231-592-1361

Name: _____ Reason for Leaving: _____

Patient information:

Patient name: _____ M / F DOB: _____/_____/_____
Phone: (home)_____ (cell)_____
Address: (street)_____
City: _____ State: _____ Zip: _____

Location Preference:

☐ Big Rapids Office- 20095 Gilbert Road ☐ Grand Rapids Office- 4024 Park East Court

Referring Physician

Name: _____Phone: _____ Fax: _____

Primary Care Physician

Name: _____ Phone: _____ Fax: _____

Insurance Information

Primary Insurance: _____Policy #: _____Group #:_____

Secondary Insurance: _____Policy #:_____ Group #: _____

Please fax any previous studies or treatments that coincide with the referral to fax: 231-592-1361

Examples; previous X-RAY, MRI , CT, & Pain Management Records

THIS SECTION IS FOR AUTO/WORK RELATED PATIENTS:

IS THIS AUTOMOTIVE RELATED? Y / N **IS THIS A WORK RELATED INJURY Y / N**

AUTO/WORK COMP INSURANCE: _____ CLAIM # _____
ADDRESS: _____ STATE: ____ ZIP_____ DOI: ___/____/_____
ADJUSTERS NAME :_____ ADJUSTERS PHONE: _____