Graphical user interface, application

Description automatically generated with medium confidence REFERRAL FORM

Thank you for choosing Premier Pain & Spine. We are committed to providing our patients the highest quality of care. Our assessment, treatment, and prevention services focus on enriching the lives of the people we serve.

The following is a list of information needed for the patient referral:

* Referring Physician
* Diagnosis for referral
* Patient Demographics including insurance information
* Last two (2) Physician notes
* Current imaging (x-ray, MRI, CT report)
* Medication list

Once all the above information is received and it is determined by Physician/Director if the patient is a candidate for our practice appointment will be scheduled and patient will be notified.

Our providers offer various modalities to decrease pain (injections, orthopedic braces, TENS unit, therapy, medications, etc.). Our providers may prescribe medications at their discretion and in accordance with current Center for Disease Control (CDC) guidelines.

Please call Lisa with any questions you might have regarding referral at 256-203-4844.

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**OFFICE HOURS:**

* Monday through Thursday 8:00am-5:30pm. We are closed all major holidays.

**INSURANCES ACCEPTED:**

* Medicare
* BCBS
* United Health Care
* Humana
* Aetna
* Cigna
* Cigna Healthsprings
* Tricare

**PRIVATE PAY PATIENTS:**

* Initial visit $200.00
* Follow up visit $100.00

We look forward to hearing from you!

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Description automatically generated **Referral Form**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referring Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referring Physician Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Attached in referral:**

|  |  |
| --- | --- |
|  | Patient Demographics |
|  | Copy of Insurance cards |
|  | Last 2 office notes |
|  | Imaging |
|  | Medication list |
|  |  |

Comment: