Referral Request Form

TOUCHSTONE
INTERVENTIONAL PAIN CENTER

Shawn Sills, MD
Anesthesiologist Specializing in Pain Management

Patient Information

Patient Name: ______________________________

DOB: ______________ Sex: M or F SS#: ______________

Phone: ______________ Work/Cell: ______________

Address: ______________________________

City: ______________ State: ________ Zip: ________

Referring Provider Information

Referring Provider: ______________PCP: ______________

Office Contact: ______________ Phone: ______________ Ext: ________

Reason for Referral

❍ New Patient Evaluation and Treatment

_____Take Over Pain Medication Management (Medications not prescribed on first visit)

_____Return when stable

❍ Recommendation only

❍ Procedure only Specify: ______________________________

Referral Triage: ❍Routine ❍Urgent ❍Emergent (Provider to Provider Call)

Reason for visit: ______________________________

Diagnosis: ______________________________

❍ Suboxone inductions for opiate detox

****Please include a copy of the insurance card, chart notes, lab work, and most recent chart notes****

Insurance

Primary Insurance:______________ Policy/ID Number: ______________

Group Number: ______________ Group Name: ______________

Secondary Insurance: ______________ Policy/ID Number: ______________

Group Number: ______________ Group Name: ______________

❍Worker's Compensation ❍Motor Vehicle Accident

Insurance: ______________ Claim Number: ______________

Date of Injury: ______________ Authorization Number: ______________

Adjuster Name: ______________ Phone: ______________ Ext: ________