McLaren
GREATER LANSING

Pain Management Center
2720 South Washington Avenue, Suite 250
Lansing, Michigan 48910
(517) 975-6625 – FAX: (517) 975-6630

Thank you for your referral. Please complete this form in its entirety. The following information **must** be received to see the patient. We will contact the patient for an appointment.

1) Radiological Studies (reports)
2) Complete Medication List
3) Medical History (progress notes)

FAX REFERRAL FORM

Name:_____
Address:_____
City:_____Zip Code:_____
Home Phone:_____Cell Phone:_____
DOB:_____ SS#_____

Insurance:_____Contract#_____
2nd Insurance:_____ Contract#_____
Work Related: Y or N Claim/Auth#_____
Auto Injury: Y or N Claim/Auth#_____

Diagnosis:_____
Has this patient been seen here before?_____If yes, When?_____

Referring Physician:_____
Address:_____
City:_____Zip Code:_____
Contact Person:_____
Phone:_____Fax:_____

Appointment Verification

☐ **Monday** ☐ **Tuesday** ☐ **Wednesday** ☐ **Thursday** ☐ **Friday**

Date:_____Time:_____

Physician:_____

Please advise your patient to obtain necessary authorization needed for an appointment with the Pain Management Center. Co-pays will be collected at the time of visit.
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