# The Center for Pain Relief

**400 Court Street, Suite 100 Charleston, WV 25301 Phone (304)347-6120 Fax (304)347-6205**

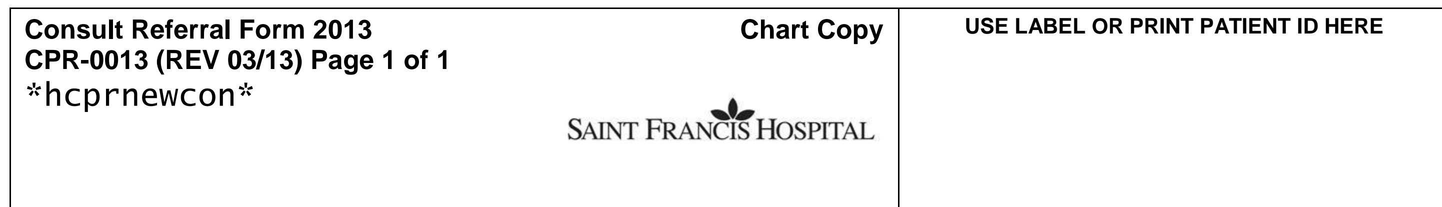
## NEW PATIENT CONSULT

| Information Requested | Completed Information |
|---|---|
| Date: | |
| **Requesting Physician:** | |
| Requesting Physician UPIN #: | |
| Requesting Physician NPI #: | |
| Office Address: | |
| Office Phone Number: | |
| **Patient Name (Last, First, Middle Initial):** | |
| Date of Birth: | |
| Social Security Number: | |
| Home Address: | |
| Home Phone Number: | |
| Work/Alternate Phone Number: | |
| **Reason For Consult** | |
| Is this an Auto Accident Injury: | ( ) Yes ( ) No |
| Is this a Work Related Injury: | ( ) Yes ( ) No |
| Insurance Type: | |
| Referral or Authorization Number: | |
| If applicable Workers Compensation D.O.I.: | |
| • Workers Compensation Claim Number: | |
| • Allowed Diagnosis Codes | |
| • Case Manager (Name and Phone #) | |

**Please provide the following information along with the referral to avoid delays in scheduling.**

- **All Medical Records including MRI and Radiology Reports, Office Notes, Etc.**
- **Copy of Insurance Cards**
- **Copy of Authorization and or Referral Number when applicable (Workers Compensation, Carelink, Aetna, Cigna, Etc.)**

**New Patient Consultation is a consult only, and does not guarantee medication management.**
**Thank you for your referral. If you have any questions or your referral has not been processed within 2 weeks, please feel free to contact the Center.**



**Consult Referral Form 2013**
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**Chart Copy**



**USE LABEL OR PRINT PATIENT ID HERE**