



**Martin J. Andrews, MD**

**Board Certified**

**American Board of Pain Medicine  
American Board of Anesthesiology**

FOR OFFICE USE ONLY:

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### REFERRAL FORM

#### PATIENT INFORMATION

PATIENT NAME: \_\_\_\_\_ SEX: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY, STATE, ZIP \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

DIAGNOSIS: \_\_\_\_\_ ASA/BLOOD THINNERSS? \_\_\_\_\_

REASON FOR REFERRAL? \_\_\_\_\_

- CONSULT ONLY
- EVALUATE/TREAT
- MEDICATION RECOMMENDATIONS

#### INSURANCE INFORMATION

PRIMARY: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

IDENTIFICATION NUMBER: \_\_\_\_\_ GROUP NUMBER: \_\_\_\_\_

SECONDARY: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

IDENTIFICATION NUMBER: \_\_\_\_\_ GROUP NUMBER: \_\_\_\_\_

BWC CLAIM? MCO: \_\_\_\_\_ DOI: \_\_\_\_\_ CLAIM NUMBER: \_\_\_\_\_

#### REFERRING DOCTOR INFORMATION

REFERRING DR. \_\_\_\_\_  MD  DO  DC SPECIALTY: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY, STATE, ZIP \_\_\_\_\_

PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_ E-MAIL: \_\_\_\_\_

PCP: \_\_\_\_\_  MD  DO PHONE: \_\_\_\_\_

POR (BWC only): \_\_\_\_\_  MD  DO  DC SPECIALTY: \_\_\_\_\_

#### PLEASE FAX THE FOLLOWING INFORMATION TO HELP US PROVIDE QUALITY CARE FOR YOUR PATIENT

- CURRENT MEDICATION LIST
- ANY RADIOLOGY REPORTS
- MOST RECENT OFFICE NOTE
- NAMES OF PAST PAIN MGNT DOCTORS AND NOTES IF AVAILABLE
- COPY OF INSURAMNCE CARDS