OhioHealth Pain Management
801 OhioHealth Blvd Suite 270
Delaware, OH 43015
Phone: 740-615-0310
Fax: 740-615-0312

Referral Form

Date_____ ___ First Available ___ Dr. Patel ___ Dr. Seidensticker

Please fax this completed form to 740-615-0312 with the following information. We will call the patient directly.

- **Copy of patient's insurance card**
- **Physician Notes**
- **Testing, including MRIs, X-Rays, and EMGs**

Patient Name: _____ DOB: _____

Social Security No.:_____-_____-_____ Diagnosis:_____

Home Phone: _____ Cell Phone: _____

Address: _____

Referring Physician: _____ Physician Phone: _____ Fax: _____
(Print first & last name) PCP: _____

Reason for Referral: ☐ **Evaluation and Treatment**
☐ **Evaluation and Procedure Only:** _____
(Input requested procedure)

***Please Note* This office does not write prescriptions for controlled substances on initial visit.**

Worker's Compensation
Claim #:_____ Date of Injury: _____
Physician of Record: _____ Allowed Diagnosis: _____
Employer through which claim was filed: _____

Motor Vehicle Accident: ☐ Yes ☐ No **Litigation:** ☐ Yes ☐ No

Insurance: *Complete insurance information if copy of insurance card not attached.*
Primary Insurance: _____ Subscriber: _____

Subscriber ID: _____

Secondary Insurance: _____

Office Staff

Received Date: _____

Appointment Date: _____

Appointment Time: _____