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: ___________________