

**ADVANCED PAIN MEDICINE ASSOCIATES**

**\*\*Providing Hope for Pain Sufferers\*\***

**3715 N. Oliver Street, Wichita, KS 67220 Tel. 316.942.4519 Fax 316.942.4655**

**JON C. PARKS M.D. GEORGE. G. FLUTER M.D.**

**Rita Simpson P.A. Lien Graham P.A. Linda Bayless ARNP**

**● PAIN MANAGEMENT REFERRAL**

Today's Date: \_\_\_\_\_

Ordering Physician: \_\_\_\_\_ Tel: \_\_\_\_\_ Fax: \_\_\_\_\_

Contact person: \_\_\_\_\_ Tel: \_\_\_\_\_ Ext. \_\_\_\_\_

**\*\*\*IMPORTANT \*\*\***

**MEDICAL RECORDS MUST BE RECEIVED**

Dr. Parks requires record review to determine acceptance to our clinic prior to scheduling an appointment. All medical records and any recent radiology and lab reports pertinent to your patient's diagnosis is required. Failure to send these records will only delay this process for your patient.

PATIENT: \_\_\_\_\_ DOB: \_\_\_\_\_ Tel: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Has pt. been seen by another Pain Specialist?  Y  N

If YES-who: \_\_\_\_\_ Any pain injections done?  Y  N When: \_\_\_\_\_

Please specify below what you are referring your patient for: **CHECK ALL THAT APPLY**

- |  |  |
|--|--|
| <input type="checkbox"/> Epidural Injections                 | <input type="checkbox"/> Other Peripheral Nerve Blocks         |
| <input type="checkbox"/> Selective Nerve Root Blocks         | <input type="checkbox"/> Other Joint Injections please specify |
| <input type="checkbox"/> Facet Joint Injections              | <input type="checkbox"/> Eval for Spinal Cord Stimulator       |
| <input type="checkbox"/> Discography list # of levels: _____ | <input type="checkbox"/> Eval for Intrathecal Pump             |
| <input type="checkbox"/> SI Joint Injection                  | <input type="checkbox"/> Disability Eval with Dr. Fluter       |
| <input type="checkbox"/> Epidural Blood Patch                | <input type="checkbox"/> Consult with trmt recommendations     |
| <input type="checkbox"/> Trigger Point Injections            | <input type="checkbox"/> Medication Management                 |
| <input type="checkbox"/> Occipital Nerve Blocks              | <input type="checkbox"/> Other: _____                          |

**THE FOLLOWING MUST BE FAXED**

- **PATIENT DEMOGRAPHIC INFORMATION**
- **A CLEAR COPY OF THE INSURANCE CARD(s), FRONT AND BACK, SO WE MAY CALL TO CHECK COVERAGE.**
- **PROGRESS NOTES**
- **MRI/SCAN REPORTS**
  
- **PCP's, please send a referral if the patients insurance requires one.**
- **If MVA please provide: accident date, insurance company, health coverage**
- **IF Work Comp please send: billing address, claim #, pt. attorney, work comp contact name and number.**
- **\*\*\*\*We do not participate with any State Medicaid Programs.**

**TO INSURE PROMPT SCHEDULING FOR YOUR PATIENT THIS FORM MUST BE COMPLETED AND THE REQUESTED INFORMATION BE FAXED.**

**We appreciate your referral and look forward to providing quality care for your patients.**

Talana Jameson  
New Patient Coordinator ☺  
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