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Mooreville, NC 28117



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LAKE NORMAN  
ANESTHESIA ASSOCIATES  
&  
PAIN MANAGEMENT

NEW PATIENT REFERRAL FORM

PROVIDER REQUESTED:

Patrick Laguerre, MD

Kelly Quinn, NP

PATIENT NAME: \_\_\_\_\_  
First Middle Last

DATE OF BIRTH \_\_\_\_\_ SS#: \_\_\_\_\_

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

ADDRESS: \_\_\_\_\_

ALLERGIES: \_\_\_\_\_

BLOOD THINNERS:  Yes  No If Yes: (Name of Medication) \_\_\_\_\_

PT/PTT ORDERED:  Yes  No

Referring Provider (MUST have seen the patient for their current pain issue within the past 6 months)

Provider's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Practice Address: \_\_\_\_\_

NPI: \_\_\_\_\_ Fax #: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ Subscriber's DOB: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ Subscriber's DOB: \_\_\_\_\_

\* When faxing insurance card(s), please send LEGIBLE copies

Location of Patient's Pain: \_\_\_\_\_

Treatment requested: \_\_\_\_\_

Has the patient been seen at another Pain Clinic? If so, please give us their name and address.

\_\_\_\_\_  
\_\_\_\_\_

Please fax the following with this form for the patient's appointment to be scheduled in a timely manner:

Insurance Card(s) \*  Medication List  Records pertinent to the patient's current pain

MRI/CT scans (if available)  Records from other pain management clinics (if available)

LNAA USE ONLY

DATE/TIME OF APPT: \_\_\_\_\_ Patient Notified: Yes / No

CALLED PT. TO SCHEDULE APPT. (1) \_\_\_\_\_ (2) \_\_\_\_\_

APPT. NOT SCHEDULED \_\_\_\_\_

\_\_\_\_\_