146 Medical Park Road, Suite 108
Mooresville, NC 28117

LAKE NORMAN
ANESTHESIA ASSOCIATES
&
PAIN MANAGEMENT

Phone: 704-662-0877
Fax: 704-662-0875

NEW PATIENT REFERRAL FORM

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 _____

_____