



TRIDENT PAIN CENTER, PA

9267-G Medical Plaza Drive, North Charleston, SC 29406
Phone (843) 797-3636 Fax (843) 797-3637

REFERRAL FORM:

Please include the following information with the completed Referral Form:

- (1) The patient's last several office notes*
- (2) All MRI and X-ray reports for this patient*
- (3) Copies of the patient's insurance cards*

Patient Name: _____

Date of Birth: _____ **Social Security #:** _____

Address: _____

Home #: _____ **Work #:** _____ **Cell #:** _____

Primary Insurance: _____ **ID #:** _____

Secondary Insurance: _____ **ID #:** _____

Tertiary Insurance: _____ **ID #:** _____

Referring Physician: _____ **Phone #:** _____

Reason for Referral Including Location of Pain: _____

Does the patient have an active WORKER'S COMPENSATION case?

_____ **No**

_____ **Yes** (*Please provide Worker's Compensation information including AUTHORIZATION for evaluation*)

Is the injury a result of a MOTOR VEHICLE ACCIDENT?

_____ **No**

_____ **Yes** (*Please provide Attorney's name and contact information*)

Has the patient had NECK OR BACK SURGERY? _____ **Neck** _____ **Back** _____ **Neither**

Thank you for referring your patients to Trident Pain Center! We will contact the patient to schedule an appointment and we will notify you of the appointment date/time. If you have any questions, please call Charlene, our Referral Coordinator, at (843) 797-3636 ext. 207.