TRIDENT
PAIN CENTER

Lexington | Columbia | North Charleston | Moncks Corner | Walterboro | Mount Pleasant

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 #:** _____

Patient Email: _____

Primary Ins.: _____ **ID #:** _____

Secondary Ins.: _____ **ID #:** _____

Tertiary Ins.: _____ **ID #:** _____

Referring Physician: _____

NPI: _____ **Tax ID:** _____

Phone #: _____ **Fax #:** _____

Reason for Referral Including Location of Pain: _____

_____

Does the patient have an active WORKER'S COMPENSATION case? Date of Injury (mm/dd/yy)_____

_____ **No**
_____ **Yes** *(Please provide Worker's Compensation information including AUTHORIZATION for evaluation)*

Is the injury a result of a MOTOR VEHICLE ACCIDENT? Date of Injury (mm/dd/yy)_____

_____ **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 contact our Referral Coordinator at referrals@tridentpaincenter.com.