



**TRIDENT**  
PAIN CENTER

**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:** \_\_\_\_\_

**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: (843) 797-3636 ext. 207 or [Charlene@tridentpaincenter.com](mailto:Charlene@tridentpaincenter.com).*

main: 843.797.3636 fax: 843.797.3637 | [tridentpaincenter.com](http://tridentpaincenter.com)

North Charleston: 9267 Medical Plaza Drive, North Charleston, SC 29406  
Moncks Corner: 108 North Hwy. 52, Moncks Corner, SC 29461  
Walterboro: 302 Medical Park Drive, Ste. 207-A, Walterboro, SC 29488