



TRIDENT

PAIN CENTER

Patient Self-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 #: _____

Email Address: _____

Primary Ins.: _____ ID #: _____

Secondary Ins.: _____ ID #: _____

Tertiary Ins.: _____ ID #: _____

Current 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 your interest in Trident Pain Center! We will you to discuss the self-referral and schedule an appointment.

If you have any questions, please contact our Referral Coordinator: (843) 797-3636 ext. 207 or

Charlene@tridentpaincenter.com.

main: 843.797.3636 fax: 843.797.3637 | 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