GREENVILLE HEALTH SYSTEM
Interventional Pain Management Associates

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Referring Practice: _____
Referring Physician: _____
Office Phone: _____ Office Fax: _____
Referral Contact: _____ Referral Contact #: _____

Patient name: _____ DOB: _____ SSN: _____
Patient contact phone #: _____ Secondary #: _____
Patient contact address: _____
_____
Insurance: _____ ID number: _____
Secondary: _____ ID number: _____

Reason for Consultation:

◯ Back pain
◯ Cancer pain
◯ Other _____
◯ Neck pain
◯ Extremity pain

Has this patient been seen by any other pain physician?

◯ Yes: Physician name: _____ Practice Name: _____
◯ No

Is this a worker's compensation case?

◯ Yes
◯ No
W/C contact: _____ Contact phone: _____
Claim #: _____ DOI: _____

Additional Comments:

_____

_____

Please provide all relevant clinic notes and any imaging studies along with this referral. Please send a copy of the patient's demographics and insurance information.