CENTER for PAIN MANAGEMENT

440 B High Street
Bowling Green, KY 42101

Tel: 270-282-7116
Fax: 270-282-7121

RAM PASUPULETI, M.D.

PATIENT REFERRAL FORM

REFERRING PHYSICIAN

Name: ____ (USE ADDRESS STAMP IF AVAILABLE)

Specialty: ____

Address: ____

Tel: ____

Fax : ____

Reason for Referral: ____

Kindly Fax or Mail any reports of Diagnostic Imaging (MRI, CT, EMG, XRAY etc) with this form

PATIENT INFORMATION

Name: ____ DOB: ___/____/_____ SSN: _____- _____- ______

Tel: Home: _______________________ Work: _______________________ Cell: ________________________

Address: ___________________________ City: _________________________ State:_____ Zip: ___________

Insurance
Primary insurance: ________________________________ Policy Number: _____________________________

Insurance Billing Address: ____

Secondary Insurance
(If applicable): __________________________________ Policy Number: _____________________________

Insurance Billing Address: ____

Is this related to an auto accident □Yes □No Is this related to Worker's Compensation □Yes □No

Date of Injury:___/___/____ Claim#: ______________ Visit approved by Worker's Compensation □Yes □No

Adjustor: ____ Tel: _______________________________________

Address: ____