Beresh Pain Management

Treating patients like family

PATIENT REFERRAL FORM

Please fax to (513) 737-6601

Name________________________ Ref. Physician______________________

D.O.B.______________________ NPI #____________________________

Insurance*_____________________ Office Contact______________________

Pt Phone______________________ Office Phone______________________

Alternate Number_______________ Office Fax_________________________

***IF this is a workman's comp case make sure you fax us over a copy of the approved C-9 for Pain Management Consultation. No BWC pt will be scheduled Until we have an approved C-9 from the referring physician. Thank You**

Physician Requesting: _____Consult Only _____Injection Only _____Transfer Care

_____Other :____

Diagnosis:____

If injection requested, type and number:____

Additional Comments:

Your patient will not be scheduled without the proper documentation.

Please send last two months of office note; any MRI, CT scan, or EMG reports; urine drug screens, medication list and insurance card copy. If workman's comp case, make sure we have a copy of the approved C-9.

Signature ____ Date _________________

840 N.W. Washington Blvd. Suite C • Hamilton, OH • 45013

513–737–PAIN (7246)

Bereshpainmanagement@ Yahoo.com • FAX 513–737–6601