REFERRAL SHEET

CONSULTANTS IN PAIN MEDICINE

DIAGNOSIS · TREATMENT · RELIEF

Thomas Runyan, MD **Kevin Coyle, MD**

Brunswick & Camden
Phone (912) 466-9111
Fax (912) 466-0366

Vidalia & Savannah
Phone (912) 537-4414
Fax (912) 537-4437

Waycross
Phone (912) 283-6877
Fax (912) 283-6879

Services Requested: Pain Management Evaluation and Treatment
Procedure (Specify) _____

Patient Information:

Patient Name: _____

SS# _____ DOB _____

Address: _____

Home Phone: _____ Work: _____ Cell: _____

Diagnosis: _____

Insurance Information: **MUST HAVE PRIOR TO SCHEDULING**

Primary Insurance: _____

Secondary Insurance: _____

PCP: _____

Attorney or WC Contact Name _____

Phone: _____ Fax: _____

Claim #: _____ Date of Injury _____

Can we administer medication through our office? YES / NO

Referring Physician Information:

Date: _____ Referring Physician: _____ Contact: _____

Office Phone: _____ Fax _____ NPI# _____

*****Please send demographic information, medical records and MRI or XRAY reports. Upon receipt of this completed form and the necessary medical records, we will contact the patient to schedule an appointment.*** Thank you for your referral!!**