CULLMAN REGIONAL | Medical Group

INTERVENTIONAL PAIN CLINIC
Victoria Clay, MD
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Phone: 256-735-5560 **Fax:** 256-801-7364

PAIN CLINIC REFERRAL FORM

Date: _____ Referring Physician: _____

Office Phone Number: _____ Fax Number: _____

Patient Name: _____ DOB: _____

SSN: _____ Home Phone: _____ Alternate Phone: _____

Emergency Contact (outside of home): _____

Insurance: _____ Policy #: _____ Group #: _____

Secondary: _____ Policy #: _____ Group #: _____

PRIOR TO ANY APPOINTMENTS, WE WILL REQUIRE THE FOLLOWING:

- Any required insurance referrals (Medicaid, Healthsprings, Viva, Tricare)
- Recent Office Notes
- Physical Therapy Notes
- MRI, CT, Bone Scans
- Current Medication List (anticoagulants, Cardiac, Diabetes, NSAIDS or ASA)
- Copy of insurance cards (front and back) and driver's license

Diagnosis: _____ ICD-10 Codes: _____

Referring Physician Signature: _____ Date & Time: _____

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