



**PAIN CLINIC**

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# 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 # \_\_\_\_\_

- If work comp., we will need: date of injury, claim number, contact person, phone number, address, place of employment at time of injury, name of person whom obtained approval. Their phone number and which procedure code (s) are approved.

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 (reports only, NO films or disc)
- Current Medication List (anticoagulants, Cardiac, Diabetes, NSAIDS or ASA)
- Copy of insurance cards (front and back) and driver's license

\*\*Signature required by physician ordering meds listed below.  
Signature gives permission for patient to be off meds for pain procedure.\*\*

**Eliquis**—skip 3 days    **Xarelto**—skip 3 days    **Effient**—skip 10 days    **Brilinta**—skip 7 days    **NSAIDS/ASA**—skip 3 days  
**Coumadin**—skip 5 days    **Plavix**—skip 7 days    **Ticlid**—skip 14 days    **Pradaxa**—skip 5 days

Signature: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ ICD-10 Codes: \_\_\_\_\_  
Procedure (s) ordered: \_\_\_\_\_  
Referring Physician Signature: \_\_\_\_\_ Date & Time: \_\_\_\_\_

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