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SPINE&PAIN
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FAX to: (989) 773-6279
www.michiganspineandpain.com
1-800-586-7992

CONSULT REQUEST

Locations: Please Check
( ) Mt. Pleasant **( ) Gaylord** **( ) West Bloomfield**

Please FAX this form, along with the appropriate patient medical information and insurance information, to the requested location. We will call your patient to schedule an initial evaluation and will notify you of the appointment date. Thank you for your consult.

Patient Name:_____ Date of Birth:_____/_____/_____ SS#_____

Address:_____ City:_____ State:____ Zip code:_____

Home Phone#:_____ Cell#:_____Work#:_____

Is this a WORK or AUTO related injury? (Circle one)

Injury Date:_____/_____/_____ Claim#:_____

Carrier:_____ Adjuster Name/Number:_____

Address:_____ Phone#:_____

Primary Insurance:_____ Insured ID#:_____ Group#:_____

( ) Spouse **( )** Self **( )** Dependent Effective Date: ____/____/____

Subscriber's Name:_____ DOB:____/____/____ SS#: _____

Secondary Insurance:_____ Insured ID#:_____ Group#:_____

( ) Spouse **( )** Self **( )** Dependent Effective Date: ____/____/____

Subscriber's Name:_____ DOB:____/____/____ SS#: _____

Reason For Consult/Additional Information: _____

Referring Physician:_____Office#:_____Fax#:_____

Address_____

Specialty/Credentials:_____UPIN#:_____State License#:_____

MS&P OFFICE USE ONLY

Date Referral Received:_____ Appointment Date:_____ Time:_____ Provider:_____

Packet Sent:_____ Physician Notified/Date/Time:_____ Employee initial:_____