Commonwealth PAIN & SPINE

Please Fax Form To:
(866) MYPAIN4
697-2464

Thank you in advance for giving us the opportunity to care for your patient. Please complete the following info and fax to our attention.

- ❑ **Jason C. Lewis, M.D.** Louisville, New Albany, Elizabethtown
- ❑ **S. Kyle Young, M.D.** Louisville
- ❑ **James Jackson, M.D.** Louisville, Elizabethtown
- ❑ **Jenna Dismore, M.D.** Louisville, New Albany, Elizabethtown
- ❑ **Brendon Coughtry, M.D.** London, Campbellsville
- ❑ **Nicolaus Winters, M.D.** Evansville, Owensboro
- ❑ **Timothy Mims, M.D.** Pikeville, London
- ❑ **Michael J. Walls, M.D.** Crestview Hills, Carrollton
- ❑ **Mark Conliffe, D.O.** Louisville
- ❑ **Katherine Williams, D.O.** Evansville, Owensboro
- ❑ **Joseph Folz, D.O.** Evansville, Jasper, Mt. Carmel, Vincennes
- ❑ **Shawn Milburn, M.D.** Lexington, London
- ❑ **Christopher Anderson, M.D.** Elizabethtown, Bardstown
- ❑ **Abby Lenhart, P.T., D.P.T.** Louisville

REFERRAL

Today's Date: _____ Patient Name: _____

Referring Provider: _____ Patient Cell #: _____

Referring Provider Phone: _____ Patient Home #: _____

Referring Provider Fax: _____ Patient DOB: _____

WE ACCEPT ALL MAJOR MEDICAL INSURANCES;
INCLUDING MEDICARE, MEDICAID AND WORKER'S COMPENSATION

AUTHORIZATION

❑ Evaluate and Treat as Appropriate ❑ Medication Management ❑ Physical Medicine/Regenerative Medicine

❑ Special and/or Specific Procedure: _____ ❑ Physical Therapy

FOCUSED PAIN (CIRCLE ALL THAT APPLY)

HEADACHE	HEAD, NECK, THROAT	CERVICAL SPINE	THORACIC SPINE
LUMBAR-SACRAL	SHOULDER	HIP	KNEE
CANCER	POST-SURGICAL CHRONIC	PHANTOM	PELVIC PAIN

COMPRESSION FRACTURE OTHER: _____

PREVIOUS NEURO OR ORTHO CONSULT? Y / N PROVIDER: _____

PREVIOUS PAIN MANAGEMENT? Y / N PROVIDER: _____

PREVIOUS CONSERVATIVE THERAPY? Y / N PROVIDER: _____

PLEASE INCLUDE ANY OF THE BELOW RECORDS, IF AVAILABLE

1. OFFICE NOTES, HISTORY & PHYSICAL
2. PATIENT DEMOGRAPHICS (MUST INCL. SSN, ADDRESS)
3. IMAGING
4. **COPY OF INSURANCE CARD(S)**

WORKER'S COMPENSATION CLAIMS

Date of Injury: _____ Claim #: _____

Adjustor Name & Number: _____

***Please attach approval for appointment.