REFERRAL FORM

Please check the physician you would like your patient to see: ☐ 1st Available Physician

☐ Matthew Mosura, M.D. ☐ Kathleen Majors, M.D.
☐ Rama Letchuman M.D. ☐ Ross Nelson, M.D.

Date: ______________________

Referring Provider: ______________________

Phone #: ______________________ Fax #: ______________________

Contact Person: ______________________

PATIENT INFORMATION

Patient Name: ______________________

Address: ______________________

City: ______________________ State: __________ Zip: __________

Phone #: ______________________ Alternate Phone # ______________________

Primary Insurance: ______________________ Secondary Insurance: ______________________

****If TriCare, please submit Prior Approval form with this referral.***

Reason For Referral: ______________________

Diagnosis: ______________________

Has the patient had MRI/X-ray performed? ☐ YES ☐ NO

Does the patient have a recent pain management MD? ☐ YES ☐ NO

If yes, Name of MD: ______________________

Is this condition from an accident ☐ YES ☐ NO

If **yes**, is there a liability claim? ☐ YES ☐ NO Does the patient have an attorney? ☐ YES ☐ NO

SUBMIT THE FOLLOWING DOCUMENTATION WITH REFERRAL

1. PATIENT DEMOGRAPHIC SHEET
2. COPY OF INSURANCE CARD OR WORKMAN'S COMP INFORMATION
3. LAST 3 OFFICE NOTES
4. MOST RECENT MRI, CT, X-RAY OR EMG RESULTS

PLEASE FAX THE COMPLETED FORM AND ADDITIONAL DOCUMENTION TO
318-629-5604

1534 Elizabeth Avenue, Suite 201 • Shreveport, LA 71101
318/629-5505 (Phone) • 318/629-5604 (Fax)
www.paincarela.com