Complete Pain Care LLC
...helping you return to you!

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CONSULTATION REQUEST FORM

Patient's Name: ______________________ Date of Birth: ____/_____/_____

Patient's Address: ______________________ Home Phone: ( )

City ______________ State ______ Zip ______ Work Phone: ( )

Primary Care Physician: ______________________ Phone: ( )

Address: ______________________

City ______________ State ______ Zip ______ email: ______________

Patient's Insurance

Name of Insurance: ______________________ Phone: ( )

Policy #: ______________________ Group #: ______________

Does patient have secondary insurance?: ______________ Policy #: ______________

Workman's Comp Claim #: ______________________ Phone: ( )

Date of Injury: ____/_____/_____

Name/Address for billing: ______________________ Fax: ( )

City ______________ State ______ Zip ______

If automobile accident - date of accident: ____/_____/_____ Covering Insurer: ______________

Requesting Physician

Name: ______________________ Are you patient's PCP? ___ yes ___ no

Address: ______________________ Office Phone: ( )

City ______________ State ______ Zip ______ Office Fax: ( )

NPI #: ______________________ email: ______________

Patient Preliminary Diagnosis/Indication for Procedure: ______________________

Specific Concern/s: ______________________

Duration of Symptoms: ______________________

Relevant History: ______________________

Current Medications (include all anti-coagulants): ______________________

Allergies: ______________________

Type of Request: _____ Consult
_____ Evaluation and treatment
_____ Injection / Procedure: ______________________

PLEASE FAX ALL IMAGING REPORTS TO (508) 665-4355

MD Signature: ______________________ Date : ____/_____/_____