CAROLINAS CENTER FOR ADVANCED MANAGEMENT OF PAIN

Commonwealth PAIN & SPINE

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

CCAMP.NPS@mypainsolution.com

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

- ❑ John C. Haasis, M.D.
- ❑ Kelby Hutcheson, M.D.
- ❑ Renju T. Joseph, M.D.
- ❑ Nisarg Patel, D.O.
- ❑ Alex Kieber, M.D.
- ❑ David Tollison, PhD

ASHEVILLE	1998 Hendersonville Rd, Ste 45, Asheville, NC 28803
ANDERSON	1506 North Fant St, Anderson, SC 29621
COLUMBIA	7021 St. Andrews Rd, Ste 1, Columbia, SC 29212
GREENVILLE	10 Enterprise Blvd, Ste 201, Greenville, SC 29615
SPARTANBURG	279 E Kennedy St, Spartanburg, SC 29302

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, MOTOR VEHICLE INJURY AND WORKER'S COMPENSATION

AUTHORIZATION

❑ Evaluate and Treat as Appropriate ❑ Medication Management ❑ Physical Therapy

❑ Special and/or Specific Procedure: _____

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 INCLUDE SSN, ADDRESS)
3. IMAGING
4. **COPY OF INSURANCE CARD(S)**

WORKER'S COMPENSATION CLAIMS

Date of Injury: _____

Claim #: _____

Adjustor Name: _____

Adjustor Number: _____

***Please attach approval for appointment.

MOTOR VEHICLE INJURY

Has the patient recently been in a motor vehicle accident? **Y / N**

If so, please provide the date

_____