PATIENT REFERRAL FORM

EliteMD Pain and Spine

Referral Date: _____

8100 Timberlake Way, Ste D, Sacramento, CA 95823
Phone: (916) 235-9292
www.EliteMDpain.com

Send referrals to
Fax: (916) 775-0319
Email: Admin@EliteMDpain.com

REFERRING CLINICIAN INFORMATION

Clinician Name:		**Specialty:**			
Practice / Clinic:					
Address:					
Phone:		**Fax:**		**Email:**	

PATIENT DEMOGRAPHICS

Last Name:		**First Name:**			
Date of Birth:		**Sex:**		**Phone:**	
Email:					
Address:					
Insurance:		**Member ID #:**			

REASON FOR REFERRAL

Chief Complaint / Reason:

Past Medical History:

Past Surgical History:

RELEVANT IMAGING & PERTINENT NOTES

Imaging Included:

☐ X-Ray ☐ MRI ☐ CT Scan ☐ Other Imaging

Supporting Documents:

☐ Imaging CD ☐ Radiology Report ☐ Consultation Notes ☐ Operative Report ☐ Lab Results
☐ Procedure Notes ☐ Prior Records ☐ Medication List ☐ Referral Letter ☐ Other

Additional Notes:

PROVIDER AUTHORIZATION

Provider Signature:	**Printed Name:**	**Date:**