REFERRAL WORKSHEET

GOSHEN PHYSICIANS PAIN MANAGEMENT
1808 Charlton Court, Goshen, IN 46526
Dr. Robert Hill/ Holly Lambdin, NP
Ph: 574-537-0423 Fax: 574-537-0440

PHYSICIAN REFERRING_______________________________ TODAYS DATE:_______________
Address (if not in our file): __________________________City_____________ State____ Zip________
Phone______________________________________Fax_____________________________________

Please check only one
( ) Please EVALUATE patient for further treatment options.
( ) Please EVALUATE AND TREAT the patient for possible ______________________, but have patient's long term follow up with our office.
( ) Please EVALUATE THE PATIENT AS A 2ND OPINION and they are to return to our office.

Diagnosis:_________________________________ Physician Signature:_________________________

Patient Information

Name________________________Ph #_____________DOB:_____________SS#____________________

Please send demographics and insurance information
Comments or Special Request

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We are sending the following to the Pain Clinic:

- ❑ Relevant office notes, medication lists, other documents that may help with treatment (this is the bare minimum requested).
- ❑ MRI of the______________________________
- ❑ CT SCAN of the __________________________
- ❑ X-RAYS of the ___________________________
- ❑ EMG of the______________________________
- ❑ MYELOGRAM of the_______________________

PLEASE FAX US THE REFERRAL SHEET AND WE WILL CALL THE PATIENT.

The hours of the Pain Clinic are: Monday through Friday 8:00 AM – 4:00 PM