

# CONSULTATION REQUEST

**Interventional Pain Medicine  
Diagnostics and Treatment Center  
1; 8/39 J kmf g avenug  
Hqnku, NY 11645**

**Phone: 718 69; '5; 22  
Fax: 718 69; '3236  
www.nypaindoc.com**

Thank you for referring your patient. Please provide the following information so that we can provide the best and fastest possible service.

**To: Rajesh Patel, MD, DATE :**

Evaluate and treat this patient for: \_\_\_\_\_

Diagnosis \_\_\_\_\_

Specific Reason for Referral \_\_\_\_\_

Physician's Signature: \_\_\_\_\_

## provider name

Provider Name: \_\_\_\_\_

Provider Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Email: \_\_\_\_\_

**Primary Medical Provider**  
(if different from above):

Name: \_\_\_\_\_

Adress: \_\_\_\_\_

Phone: \_\_\_\_\_

## Patient Information:

Patient Name: \_\_\_\_\_

Patient Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Social Security: \_\_\_\_\_

**Insurance Provider:**

Group# \_\_\_\_\_

Policy# \_\_\_\_\_

Insurance Provider's Phone: \_\_\_\_\_

\* Please fax or mail this form to us along with pertinent medical records: Clinic/hospital notes, test and imaging results( X-ray, MRI, CT, bone scan), pertinent consultations.

\*\*Please include any necessary insurance referral authorizations.