RAJESH PATEL, MD, FIPP, DABPM
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IPM
INTERVENTIONAL
PAIN MEDICINE, PC
196-17 Hillside Avenue
Hollis, NY 11423
Phone : (718) 479 3900
Fax : (718) 479 1014

Referral Form To Be Filled Out By Physician Only:

Dear Doctor, Thank you for referring your patient to our Pain Management facility. Please note that only complete referrals will be accepted (please see attached referral form). Referrals must include the reason why patient needs to see our pain specialist, a consult note/medical history, along with a list of any current medications and results from current diagnostic testing.

Patient Name:	Insurance Carrier/ID:
Date of Birth:	Contact #:

Referring MD:	Phone:
Address:	Fax:

•Reason for Referral:

_____
_____
_____

• Medical Problem List:

_____
_____
_____

• List of all current pain medications, dosage and treatments:

_____
_____

- Please attach all medical diagnostic imaging.

Only referrals containing all of the above information will be accepted. Please complete the above information and fax along with the referral letter and relevant reports to 718-479-1014. Thank you for your referral to Interventional Pain Medicine PC. We will provide assessment and a treatment plan for your patients' chronic pain problem. In some cases, treatment may be initiated by our facility, however, once stabilized, the patient will be returned to you for ongoing care alongside our continued support. If in agreement, please sign this form. We will proceed with an appointment upon receipt. Thank you.