Sussex Pain Relief Center
20728 DuPont Blvd. Suite 317, Georgetown, DE 19947
302-514-PAIN * FAX 302-253-8028
sussexpainrelief@gmail.com

Physician Referral Form

Administrative:

Patient Name:_____ DOB: _____
Address:_____
Patient Phone Number: (work) _____(home)_____(cell)_____
Email: _____
Name of Insurer:_____
Referring Physician Completing this form: _____
Phone Number for Referring Physician: _____
FAX Number for Referring Physician: _____

Clinical:

Pain Location (be specific):_____
Current Pain Meds:_____
_____
_____
Previous Pain Meds: _____
_____
_____
Previous Injections or Procedures: _____
_____
_____

Worker's Comp: _____ Auto Injury: _____

MRI:_____ X-Ray: _____

H/O Addiction or Substance Abuse: Yes No (circle one)

- If yes, please describe:_____
  _____
- Where did patient complete substance abuse treatment: _____
  _____

Type of consultation request: (circle one)

- Specific need:_____
  _____
- General referral for pain control

All paper work will be reviewed by Dr. Antony and your patient will be called for an appointment. If there are any problems or questions, we will contact you. Thank you.

Sussex Pain Relief Center
20728 DuPont Blvd. Suite 317, Georgetown, DE 19947
302-514-PAIN * FAX 302-253-8028
sussexpainrelief@gmail.com

Physician Referral Form

New Patient Referrals by Physicians

Before patients are given an appointment, the following records must be sent the Sussex Pain Relief Center by Fax 302-253-8028 or e-mail: sussexpainrelief@gmail.com

1. A Physician Referral letter
2. The most recent History and physical
3. Notes pertaining to the patient's pain problem
4. Any pertinent diagnostic tests such as MRI, CT scans, EMG or NCS
5. Patient insurance and demographic information
6. Copy of the last prescription

Thank you

DR. Antony

All paper work will be reviewed by Dr. Antony and your patient will be called for an appointment. If there are any problems or questions, we will contact you. Thank you.