LOUISIANA PAIN CARE
SPINE CARE EXPERTS

Patient Referral

Patient Name: _____ Date of Birth_____

Referring Physician: _____ Ref MD Phone #: _____

If NP is referring, who is the supervising MD:_____

Contact/Nurse: _____ Ref MD Fax #:_____

Reason for Referral: _____ Previous Appointments @ LaPainCare? YES / NO

Previous Appointments for this pain issue with any other physicians? YES / NO If so, please provide those records

Referring To: (Please ✔ after Dr name you are requesting)

First Available _____ **Ledbetter** _____ **Forte** _____ **Gordon** _____

*****The Following records <u>MUST</u> be faxed with this referral sheet*****

_____Insurance information (Insurance cards, front and back)

_____Demographic/Face sheet

_____Office Notes (last 3 notes, please include any surgery notes)

_____Diagnostics reports (MRI's/ CT's/ Bone Scan/ X-Rays/ EMG's)

_____Medication List (Current meds only)

Notes:_____

_____

*****PLEASE Fax Records & Referral Sheet to 318-807-0239**

Or email to Jcagle@lapaincare.com

210 Layton Ave Monroe, LA 71201 318-323-6405