



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 Doctor name you are requesting)

First Available _____ Ledbetter _____ Forte _____ Gordon _____ Sturdivant _____

*****The Following records MUST 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)

____ Previous pain management office notes/procedures (if applicable)

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