Martin Andrews, M.D.
The PainCare Center
Diley Ridge Medical Center

7901 Diley Road, Suite 130
Canal Winchester, Ohio 43110
614-833-1700 (ph) 614-833-1701 (fax)

New Patient Referral Form

INSTRUCTIONS

Thank you for referring your patient. All reports of any studies performed such as MRI, EMG, Xl Ray, etc., should be sent along with this referral. The PainCare Center requires patient medical records from outside referring physicians in conjunction with an upcoming appointment. Documents will be reviewed prior to contacting the patient to schedule an appointment.

We are in network with most major providers as well as BWC in all states with the exception of the following:
Cigna, Caresource, Molina, Paramont Health, Buckeye Health. If you have a question as to whom we accept, please contact our office directly.

REFERRAL INFORMATION

FAX REFERRAL TO
614-833-1701

Interventional (Procedural) Pain Management Diagnosis:

☐ Radiology Attached ☐ Recent OV Note attached ☐ Insurance Card Attached ☐ Medication list attached

Appointment Requested: ☐ **New Patient Consultation** ☐ **Returning Patient Consultation**

☐ Please indicate areas affected: LT / RT / BIL Arm / Leg /Lumbar/Cervical/Knee/ Shoulder/Other

Is visit related to an auto accident?	☐ NO	☐ YES	
Is visit related to a worker's comp injury?	☐ NO	☐ YES	
Has patient had an MRI and/or X-rays?	☐ NO	☐ YES	If yes, please send report with referral

PATIENT INFORMATION

Patient Name ☐ Male ☐ Female

DOB SSN

Parent/Guardian (if minor)

Address

Email address

Phone (Home/Work/Cell) *circle one*
Alternate Phone (Home/Work /Cell) *circle one*

Primary Insurance Name ID#

Secondary Insurance Name ID #

REFERRING PHYSICIAN

Phone Fax

Address

Referring Practitioner Name MD DO DC CNP NPI

Please indicate diagnosis/reason for visit as well as any additional information relevant to this appointment request not contained in the attached medical records:

WE ARE A PROCEDURE BASED FACILITY.

PLEASE FAX ALL PERTINENT RECORDS WITH THIS REFERRAL

APPOINTMENT SCHEDULED

Appointment with Dr. Andrews is scheduled as follows:

Date Time am / pm

PLEASE REMIND THE PATIENT OF THIS APPOINTMENT. WE WILL MAIL APPOINTMENT CONFIRMATION TO THE PATIENT.