

4024 Park East Court SE  
Suite D  
Grand Rapids, MI 49546  
616.975.1186 (ph)  
616.975.0467 (fax)



20095 Gilbert Road  
Suite B  
Big Rapids, MI 49307  
231.592.1360 (ph)  
231.592.1361 (fax)

**Referral Form**

	Big Rapids	Grand Rapids
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Patient Name: \_\_\_\_\_ M\F \_\_\_\_\_  
Phone (HOME): \_\_\_\_\_ (CELL) \_\_\_\_\_  
Phone (Contact/Work): \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ SS# \_\_\_\_\_

**Primary Care Physician:** \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Referring Physician:** \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Primary Insurance:** \_\_\_\_\_  
Policy/Case/Contract # \_\_\_\_\_ Group# \_\_\_\_\_  
Contact Person: \_\_\_\_\_ Phone: \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_  
Policy/Case/Contract # \_\_\_\_\_ Group# \_\_\_\_\_  
Contact Person: \_\_\_\_\_ Phone: \_\_\_\_\_

**Appointment for : EMG / Consult or Eval and Treat** \_\_\_\_\_

**Patient been to another Pain Clinic?** \_\_\_\_\_ **Name:** \_\_\_\_\_  
**Reason for Leaving:** \_\_\_\_\_

**Date and time of initial appointment:** \_\_\_\_\_

**Please Fax with Medical Records including x-rays, CT Scan, and/or MRI to 231-592-1361. We accept referrals by phone as well.**

**\*\*\*Please be sure to include Fax Numbers of Primary Care and/or Referring Physicians\*\*\***