CORNERSTONE PAIN MANAGEMENT

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Referred Patient: _____ Date: _____

Phone: _____ Alternate Phone: _____

Diagnosis: _____

Instructions:

_____ *Evaluate & Treat*

_____ *Specific Modalities* _____

_____ *Special Instructions* _____

_____

PLEASE FAX A COPY OF THE FOLLOWING:

Patient's insurance information
Recent history and physical report
Relevant diagnostic imaging results - MRI, CT, and/or X-ray

Referring Physician's signature: _____

Referring Physician's printed name or stamp: _____

Referring Physician's NPI# _____ ***UPIN#*** _____

Referring Physician's office phone: _____ *Fax:* _____

**(Our reports will be faxed to this number)*
NPI & UPIN # upon request