ECPC
PAIN
SPECIALISTS
Division of East Carolina Anesthesia Associates, PLLC

Unifour Pain
Treatment Center
250 18th Street Circle SE
Hickory, NC 28602
Phone: 828-324-4005
Fax: 828-315-5974

REFERRAL FORM

Patient's Name _____ Date _____

Diagnosis _____

Referring Doctor _____ Phone _____

Indicate when you wish your patient to be seen by us:
☐ Immediate (1-3 days) ☐ Next Available (1-2 weeks) ☐ Other: _____

This patient has a return appointment at this office
☐ Date _____
☐ in _____ months _____ weeks _____
☐ No Return Appointment

Please indicate treatment desired:

☐ Consult and Treat (block as appropriate)

☐ Chronic, Long-Term Pain Management

☐ Epidural Steroid Injection - C T L

☐ Selective Nerve Root Block
Side: _____ Level: _____

☐ Facet Injection/Median Branch Block
___cervical ___thoracic ___lumbar
Levels: _____ PRN _____

☐ Trigger Point Injection(s)

☐ Left ☐ Right ☐ Bilateral

☐ Sacroiliac Joint Injection

☐ Pyriformis Injection

☐ Lumbar Sympathetic Block

☐ Occipital Nerve Block

☐ Lateral Femoral Cutaneous Nerve Block

☐ Evaluate for Spinal Cord Stimulator

☐ Evaluate for Intrathecal Pump

☐ Other: _____

Referring Office Section

Pre-Certification

In order to protect the patient's insurance benefits, please call their insurance carrier(s) to check pre-certification requirements for this referral. Thank you.

☐ No Pre-Certification Required

☐ Pre-certification Information Below

Insurance Company: _____ Contact Person: _____

Insurance Company Phone Number: _____

Pre-certification Number: _____

Special Pre-certification Instructions: _____

Please forward pertinent office notes, OP reports and radiographic studies at least 5 days prior to appointment.

Please FAX completed form to (828) 315-5974

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Referral Demographics & Insurance Information

Patient's Name _____ ☐M ☐F

Birth Date _____ Social Security Number _____

Address _____ City _____ Zip _____

Home Phone _____ Work Phone _____

Marital Status ☐M ☐S ☐D ☐W Spouse's Name _____

Emergency Contact _____ Phone _____

Relationship to Patient _____ Patient's Employer _____

Worker's Compensation Only

Insurance Co _____ Date of Injury _____

Ins Address _____ City _____ State _____ Zip _____

Claim Number _____

Contact Name _____ Phone _____

Insurance Information

Primary Insurance
Insured Insurance Employer _____ Insurance Co _____

To Verify Contact _____ Phone _____

Insured _____ Insured Date of Birth _____

ID _____ Group # _____ Eff. Date _____

Secondary Insurance
Insured Insurance Employer _____ Insurance Co _____

To Verify Contact _____ Phone _____

Insured _____ Insured Date of Birth _____

ID _____ Group # _____ Eff. Date _____

Third Insurance
Insured Insurance Employer _____ Insurance Co _____

To Verify Contact _____ Phone _____

Insured _____ Insured Date of Birth _____

ID _____ Group # _____ Eff. Date _____

Referring MD _____ Referring Specialty _____

Person completing form _____ Office Phone _____ Office Fax _____

Please FAX completed form to (828) 315-5974