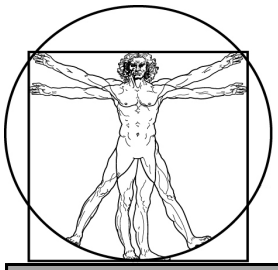

Ballard Wright, M.D., P.S.C.
2416 Regency Road
Lexington, KY 40503

The Pain Treatment Center
280 Pasadena Drive
Lexington, KY 40503

Phone: (859) 278-1316 • Fax: (859) 276-3847

New Patient Referral Form

REFERRING PROVIDER INFORMATION	
PROVIDER NAME	PRACTICE AREA/SPECIALTY
PRACTICE ADDRESS	
PHONE NUMBER	FAX NUMBER
PROVIDER NPI	CONTACT PERSON

REFERRAL TYPE

PLEASE CHOOSE ONE

☐ **FAST TRACK**
This referral is for acute, moderate to severe pain of recent onset (<1 week). Patients are seen in 24-48 hours if possible. Treatment will focus on injective therapy.

☐ **REFERRAL FOR SUBACUTE PAIN**
This referral is for pain of moderate to severe intensity with an onset <3 months. Patients are typically seen within 2 weeks.

☐ **REFERRAL FOR CHRONIC PAIN**
This referral is for pain of any intensity with an onset >3 months. Patients are typically seen in 4-6 weeks.

☐ **CONSULTATION ONLY**
This referral is for a review of the patient's pain management treatment plan only.

☐ **PROCEDURE ONLY REFERRAL**
This referral is for specified injective therapy. Indicate desired time frame for performance of procedure.

_____ ☐ 24-48 HOURS ☐ 1-2 WEEKS

PROCEDURE REQUESTED

HAS AUTHORIZATION BEEN OBTAINED? ☐ YES ☐ NO

REFERRAL REASON

PAIN DIAGNOSIS AND/OR REASON FOR REFERRAL

DOES THIS PATIENT HAVE AN IMPLANTED SPINAL CORD STIMULATOR? ☐ YES ☐ NO

DOES THIS PATIENT HAVE AN INTRATHECAL PAIN PUMP? ☐ YES ☐ NO

HAS THIS PATIENT SEEN ANY OTHER SPECIALISTS FOR TREATMENT OF PAIN? ☐ YES ☐ NO

IF YES, PLEASE LIST (FOR PURPOSES OF OBTAINING MEDICAL RECORDS)

_____

PATIENT DEMOGRAPHICS

PATIENT NAME	SOCIAL SECURITY NUMBER
DATE OF BIRTH	PHONE NUMBER

ADDRESS _____ STREET _____ CITY _____ ZIP

PATIENT INSURANCE

PRIMARY INSURANCE		SECONDARY INSURANCE	
POLICYHOLDER	DOB	POLICYHOLDER	DOB
ID NUMBER		ID NUMBER	
GROUP NUMBER		GROUP NUMBER	

HAS AUTHORIZATION BEEN OBTAINED FOR THIS REFERRAL? ☐ YES ☐ NO IF YES, PLEASE ATTACH COPY OF AUTHORIZATION

IS THIS VISIT RELATED TO A WORKER'S COMP OR AUTO CLAIM? ☐ YES ☐ NO

_____ CARRIER/COMPANY _____ PHONE NUMBER _____ CLAIM NUMBER _____ DATE OF INJURY

PLEASE FAX COMPLETED REFERRAL FORM, FRONT AND BACK COPIES OF INSURANCE CARDS, AND MEDICAL RECORDS IN ORDER TO COMPLETE THE REFERRAL. WE APPRECIATE YOUR REFERRAL AND WILL RESPOND PROMPTLY WHEN ALL INFORMATION HAS BEEN RECEIVED. YOU WILL BE NOTIFIED BY PHONE OR FAX OF THE APPOINTMENT DATE AND TIME. A PACKET WILL BE MAILED TO THE PATIENT WITH THE APPOINTMENT AND A MAP TO OUR FACILITY.