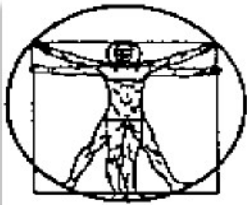

Ballard Wright, M.D., P.S.C.
2416 Regency Road
Lexington, KY 40503

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** *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** *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** *Referral is for pain of any intensity with an onset >3 months. Typically seen in 4-6 wks.*	☐ **CONSULTATION ONLY** *Referral is for a review of the patient's pain management treatment plan only.*

☐ **PROCEDURE ONLY REFERRAL** *Referral is for specified injective therapy. Indicate desired time frame for performance of procedure.* ☐ 24-48 HOURS ☐ 1-2 WEEKS HAS AUTHORIZATION BEEN OBTAINED? ☐ YES ☐ NO ***PROCEDURE REQUESTED:***	☐ **REFERRAL FOR PHYSICAL THERAPY** *Referral is for physical therapy* ☐ **Eval & Treat** ☐ **Other**________________

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? IF YES, PLEASE LIST (FOR PURPOSES OF OBTAINING MEDICAL RECORDS)	☐ YES	☐ NO

PATIENT DEMOGRAPHICS

PATIENT NAME	SOCIAL SECURITY NUMBER
DATE OF BIRTH	PHONE NUMBER
ADDRESS	
STREET	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. 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. WE APPRECIATE YOUR REFERRAL AND WILL RESPOND PROMPTLY WHEN ALL INFORMATION HAS BEEN RECEIVED.