

**Pain Management Associates**  
**G. David Bojrab, M.D.**  
**FAX REFERRAL FORM**

Fax Completed Form To: (260) 490-7254  
Office Phone: (260) 490-2525

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Social Security #: \_\_\_\_\_

Insurance: \_\_\_\_\_

***Please Be Sure To Complete The Following Patient Information:***

Patient's Area of Pain: \_\_\_\_\_

Drug Allergies: \_\_\_\_\_

Please Check If No Drug Allergies

Patient on Blood Thinner: Y  or N

If Yes, Please Specify:  Coumadin  Aspirin  Plavix Other: \_\_\_\_\_

Office Visit Requested  Procedure Requested (Type): \_\_\_\_\_

*Please Fax The Following Information Along With This Form To (260) 490-7254*

- Recent Dictation Or Office Notes
- MRI/X-Ray Reports
- Insurance Card (front and back)

Referring Physician Name/ Office: \_\_\_\_\_

Return Fax #: \_\_\_\_\_ Return Phone #: \_\_\_\_\_

**For Questions, Please Call (260) 490-2525 (ext 301)**

***We will contact your patient within 1-3 business days of receiving this fax***

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