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