THE Hemlock
Pain Center

☐ 101 Preston Court, Suite 103, **Macon, GA** 31210 (478) 745-2385
☐ 200 S. Houston Lake Rd, Suite A, **Warner Robins, GA** 31088 (478) 333-6444
☐ 109 Fairview Park Dr., Suite B, **Dublin, GA** 31021 (478) 219-3745
☐ 750 N. Cobb St., Suite 150, **Milledgeville, GA** 31061 (478) 284-0670

FAX-A-CONSULT 478-745-1225

Date____/____/_____

Patient Name__________________________________ DOB: ______/________/______________

Referring MD________________________________ NPI#______________________________

Phone No: ___________________________________ Fax No: ____________________________

Primary Care MD______________________________ Phone No: ___________________________

☐ Evaluation and Treatment ☐ Pain Management Consultation

☐ Pain Block Type of Pain Block (circle one on each line):

Cervical / Thoracic / Lumbar

Facet / Epidural / Transforaminal

☐ Spinal Cord Stimulator Trial

☐ Other: ____

Please fax the following information:

- A **legible** copy of the patient's **CURRENT** insurance card(s) (**front and back**) and patient's **demographic information.**
- A copy of a **MRI and/or CT** scan performed within the last two years of the patient's affected area.
- Copies of the **H&P** and the most recent office notes.
- **Prescription** stating "refer to the Hemlock Pain Center" for the type of block or evaluation and treatment of the designated pain area and/or diagnosis
- If applicable, please obtain worker's compensation, Medicaid, Tricare Prime or HMO and POS **approval prior to making your referral.** Appointments will **NOT** be scheduled without it. **Workers compensation referrals should include insurance company, mailing address, claim numbers, adjuster, telephone number, employer, and date of injury.**

Thank you for allowing our practice to participate in your patient's care!
We will call the patient and schedule the appointment.
You can expect prompt appointment confirmation via return fax.

Office Use Only: Date Received: _____/_____/______ Received by: __________________

Patient Appointment Date: ____/____/_____ Time ____________________

Information Not Received:

☐ Insurance Cards ☐ MRI/CT Scan ☐ Office Notes ☐ Prescription ☐ Pre-cert

☐ Other: ____

Contact Attempts: 1 __________________ 2___________________ 3_________________