



Center for Pain and Rehab Medicine

D. Terrence Foster, M.D., M.A., FAAPMR

Physician Referral Form

Fax To: 678-284-6500

Telephone: 678-284-4000

www.cpram.com

The information on this form will go directly to our referral coordinator and they will call the patient and schedule an appointment.

Please Complete The Following Fields:

***Required Fields**

Demographics:

*Last Name:

*First Name:

*Daytime phone:

(Please Include Area Code)

Gender:

Male

Female

* Date of Birth:

*Please Select Type of Insurance:

Primary:

Automobile

Medical

Workers' Compensation

Self-Pay

Insurance Co: _____ Telephone# _____ - _____

Policy No: _____ Grp No: _____

Medicare #: _____

*Type of Service Care Needed:

Office Consultation

EMG/Nerve Conduction Study Upper Extremities Lower Extremities

Independent Medical Evaluation (IME)

Therapy [PT ST OT Massage]

Medical Chart Review

Pain Management [Epidural Nerve Block Other: _____]

Wellness/Weight Loss

Worker's Compensation Examination Claims

Evaluation After Automobile Accident/Injury

Other: _____

*Patient's diagnosis:

Referral Coordinator

*Telephone No:

*Physician:

Facsimile No:

Office Address:

City, State, Zip:

Thank You For Your Referral

