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