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Pravardhan Birthi, MD
Pain Management Specialist
NEW PATIENT REFERRAL FORM

Referring Physician: _____ Office Contact Person: _____
Office Phone #: _____ Office Fax #: _____
Patient's Name: _____ Date of Birth: _____
Best Contact Phone #: _____ Social Security #: _____
Primary Insurance: _____
Pain-related diagnosis: _____
Specific Instruction: _____

To facilitate the referral process, please fax this completed form, along with:

- Copy of front and back of patient's insurance card(s) (must be received prior to review of information)**
- Copies of 2-3 most recent office notes
- Copies of any XRay/MRI/CT reports that are related to the patient's pain symptoms

We will make initial contact with the patient within 24 hours after receiving the information. If we do not feel that we can help your patient, our office will contact your office to let you know. Please list email address that we may send that information to _____

Thank you for the referral!