PAIN MANAGEMENT CENTER OF LANSING

PATIENT REFERRAL FORM

1540 Lake Lansing Rd
Suite G06
Lansing, MI 48912
Ph: 517-482-7246
Fax: 517-484-7377
www.pmclansing.com

Please include demographics, insurance cards (front/back), most recent H&P, medication list, and any relevant diagnostic reports for the last 2 years (MRI, CT scan, EMG, op-reports, injections, and Physical Therapy notes)

Date: _____ Urgent Referral: ☐ YES ☐ NO

Referring Physician: _____ Phone: _____ Fax: _____

PATIENT INFORMATION

Patient Name: _____ DOB: _____/_____/_____

Patient Address: _____ City: _____ State: _____ Zip: _____

INSURANCE INFORMATION

Primary Insurance: _____

Subscriber ID: _____

Group #: _____

Secondary Insurance: _____

Subscriber ID: _____

Group #: _____

Auto Insurance/ Workers Compensation

Carrier: _____

Claim No: _____

Date of Injury: _____

Adjuster Name: _____

Adjuster Phone: _____

REASON FOR REFFERAL

DIAGNOSIS: _____

EVALUATE AND TREAT: ☐ Neck Pain ☐ Thoracic Pain ☐ Low Back Pain ☐ Joint Pain ☐ Headaches ☐ Neuropathy

☐ Cervical Radiculopathy ☐ Lumbar Radiculopathy ☐ U/E Pain ☐ L/E Pain ☐ Other_____

TREATMENT OPTIONS: ☐ Epidural Injection ☐ Facet Injection ☐ Sacroiliac Joint Injection ☐ Headache Treatments ☐ DRG

☐ Spinal Cord Stimulator Trial ☐ Radiofrequency Ablation ☐ Joint Injection ☐ Nerve Block ☐ Other: _____

Please fax referrals to 517-484-7377

▪ Narasimha Gundamraj, M.D. ▪ Kevin Orr, D.O. ▪ Malani Gupta, M.D. ▪ Travis Lee, D.O. ▪ Luke Guminik, D.O
▪ Annette Spindler, FNP-BC ▪ Shelby Arnold, DNP-BC ▪ Laura Timm, DNP-BC ▪ Emily Felsing, FNP-BC