Advanced Pain Solutions
Columbus Regional Healthcare System

320 Jefferson Street
Whiteville, NC 28472
Phone: (910) 642-9835
Fax: (910) 640-5219

Referral Form for

Advanced Pain Solutions

___ First Available ___ Dr. X ___ Dr. Y

Referring Physician: _____ Phone:_____ Fax:_____
(Print first & last name)

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Please fax this completed form to (Fax) (910) 640-5219 with the following information:

Copy of patient's insurance card, Physician Notes, physical therapy notes, and any Testing, including MRIs, x-rays, and EMGs
We will call the patient directly.

Patient Name: _____DOB: _____Patient Zip Code_____

Phone: _____ Alternative Phone: _____

Patient Address: _____ Social Security No. _____-_____-_____

City: _____Zip Code: _____

Primary Insurance Type: Commercial_____ Medicare_____ Medicaid_____ Self-Pay____ Work Comp____

If Worker's Compensation, please fill out below information

Claim # _____ Date of Injury: _____

Physician of Record _____ Allowed Diagnosis: _____

Employer through which claim was filed: _____

Motor Vehicle Accident: € Yes € No **Litigation:** € Yes € No