Holzer

Holzer Lawrence County
PAIN MANAGEMENT REFERRAL GUIDELINES

Dear Referring Physicians:

Thank you for allowing us to participate in your patients care. However, due to the increase in pain management referrals, we are sending out reminders of our referral guidelines.

1. Patient must be established with referring physician for **6 months prior to referral** to establish need for pain management services.

2. When sending referrals, please include all diagnostic testing, drug screens, the last 3 office notes, medication list, Patient demographics, complete address, home and/or cell phone number, copies of insurance cards, referring physicians address, phone and fax number.

3. Please make arrangements for your patient if they are currently on any type of narcotics for their pain control, as our physician will not write narcotics until his evaluation is complete. Completion of evaluation entails initial assessment, drug screen confirmation and any diagnostic testing results he ordered to have been received and reviewed by the physician. Your patient needs to be made aware Narcotics **will NOT** be written at the first appointment. Once the physician determines medical necessity, he will then write what he deems appropriate for the patient's condition.

Once we receive your referral and it has been reviewed by the physician, we will contact your office to let you know if we can offer any assistance to your patient. Once the patient has been scheduled, we will send them a new patient packet in the mail to be completed and brought with them at their appointment. Please make your patient aware of this process.

Once the patient has been referred to and established with pain management, the patient must continue to follow up with the primary care physician for all other medical needs. Patient must remain under the care of a primary care physician while in pain management.

Our goal is to get your patient scheduled as soon as possible. However, due to an increased volume of referrals, please allow our office up to 2 -3 weeks for this process. Please inform your patient of the referral process and explain it could take several weeks before they receive their new patient packet in the mail. Please make sure your patient is aware of this process and the timeframe involved.

Thank you for your continued referrals and allowing us to participate in your patients care.

PHYSICAL MEDICINE AND REHABILITATION
GLEN P. IMLAY, MD
98 State Street • Proctorville, OH 45669
Phone: 740-886-9370; Fax: 1-844-821-0572

PLEASE NOTE: New Patients **will NOT** be prescribed narcotics on their first visit. Please make arrangements for your patients who are currently taking narcotic medications until the physician has determined medical necessity.

Please fax any records pertaining to the reason of visit including x-ray, MRI's, or any other type of diagnostic testing, office notes including drug screens and medication lists. Also, please include a copy of the insurance card.

Reason (s) for treatment: _____

_____

_____

Date: _____ Referral from: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Fax: _____

Contact Person: _____

PATIENT INFORMATION

Patient Name: _____ M F DOB: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Cell / Alternate Phone: _____

Social Security Number: _____ Married Single Widowed Divorced Separated

Has the patient ever been seen by another Pain Clinic? YES NO

If "YES," where and when? _____

EMPLOYER INFORMATION:

Employer: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: _____

INSURANCE INFORMATION (Please note: We do not accept KY Medicaid)

If the patient's insurance requires a prior authorization, we must have the prior authorization number and a copy of such prior to being scheduled for the first appointment. If no prior authorization is required, please indicate NOT REQUIRED in the authorization line.

Insurance Carrier: (PRIMARY): _____ Insurance Carrier (Secondary): _____

Policy / Claim number: _____ Policy / Claim Number: _____

Policy Holder: _____ Policy Holder: _____

Authorization: _____ Dates: _____ Per: _____

*************FOR STAFF USE ONLY*************

Referring office contacted Date: _____ Time: _____ Via Fax: _____ Phone: _____

Letter mailed to patient Date: _____ Initials: _____