TRIANGLE
PAIN INSTITUTE

Triangle Pain Institute
2605 Blue Ridge Rd
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Raleigh, NC 27607

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Fax: 984-242-0954
Website: www.trianglepaininstitute.com

Patient Referral Form

Patient Demographic Information

Patient Name: _____
Street Address:_____
City/State/Zip:_____
Phone Number: _____ Email Address: _____
DOB: _____ SSN: _____
Patient's Employer: _____
Patient's Primary Care Physician: _____
Patient's Primary Insurance: _____
Patient's Secondary Insurance: _____

Referring Provider

Referring Physician: _____
Address:_____
Office Phone Number:_____ Fax: _____
Office Contact: _____ Email Address: _____

Reason for Referral

What is the reason for referral? Please check one.

___ Consideration for the following procedure: _____
___ Consultation with recommendations made for pain management.
___ Evaluate and assume responsibility for pain management.

Medical Imaging and Required Documentation

Please fax this completed form to the fax number listed above with the following:

___ Copy of the patinet's insurance card(s) **(front and back copy)**
___ Copies of 2-3 most recent office notes
___ Copies of any X-ray/MRI/CT reports relating to the patient's pain

Once received and approved our office staff will contact the patient directly to schedule the appointment. If for some reason the referral is not accepted or the patient declines to schedule an office visit, we will notify your office as soon as possible. Thank you!