Twin Cities Pain Clinic

PATIENT REFERRAL FORM

Referrals Fax: **952-841-2346**
Referrals Phone: **952-204-3547**
Referrals Email: **referrals@tcpain.com**

- Include last six months of office notes and radiology reports with this referral
- **PROCEDURE ONLY REFERRALS** - An order must be included with this referral

☐ **Check if TCPC provider will determine procedure and level.**

PATIENT INFORMATION

First name_____ **Last name**_____

Date of Birth_____ **Cell phone**_____ **Alt phone**_____

Email address_____ **Preferred language**_____

REFERRING PROVIDER INFORMATION

First name_____ **Last name**_____ **Cell phone**_____

Email:_____ **Fax:**_____

Clinic/Hospital:_____ **Clinic/Hospital phone:**_____

INSURANCE INFORMATION

Primary Insurance_____ **Secondary Insurance**_____

Policy #_____ **Group #**_____ **Policy #**_____ **Group #**_____

REASON FOR REFERRAL

Describe pain issue_____

_____

☐ **Clinical evaluation** ☐ **Procedure** *(specify procedure below)* ☐ **Other** *(specify below)*

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