



**ProCareWellnessInstitute**  
JOINT PAIN TREATMENT CENTERS

FAX THIS FORM TO:

**912.304.5624**

NEW PATIENT SCHEDULING PHONE: 912.348.3818

referrals@jointpainmds.com

## JOINT PAIN TREATMENT REFERRAL FORM

Today's Date:		Patient DOB:	
Patient Name:		<input type="checkbox"/> M <input type="checkbox"/> F	
Primary Care Physician:		Phone:	
<b>PATIENT DEMOGRAPHICS</b> (may attach face sheet instead)			
Address:	City:	State:	Zip:
Phone:		Alternate Phone:	
<b>PATIENT INSURANCE INFORMATION</b> (may attach face sheet instead)			
Primary:	ID#:	Group#:	
Phone:			
Secondary:	ID#:	Group#:	
Phone:			
<b>REFERRAL REASON</b>	<b>Wound Location</b>	<b>Wound Size</b>	
<input type="checkbox"/> Knee pain	<input type="checkbox"/> Frozen shoulder	<input type="checkbox"/> Rotator Cuff injury	
<input type="checkbox"/> Hip pain	<input type="checkbox"/> Back pain	<input type="checkbox"/> Elbow pain	
<input type="checkbox"/> Bursitis	<input type="checkbox"/> Tendonitis	<input type="checkbox"/> Degenerative Disk Disease	
<input type="checkbox"/> Sciatic pain	<input type="checkbox"/> Carpal Tunnel	<input type="checkbox"/> Plantar Fascitis	
<input type="checkbox"/> Other			
ADDITIONAL COMMENTS:			
Does Patient have a cardiac pacemaker/defibrillator?		<input type="checkbox"/> No <input type="checkbox"/> Yes	
Does Patient have an infusion pump?		<input type="checkbox"/> No <input type="checkbox"/> Yes	
Does Patient have a bleeding disorder?		<input type="checkbox"/> No <input type="checkbox"/> Yes	
<b>REFERRER INFORMATION</b>			
Name:	Phone:	Fax:	
Referral Source:	<input type="checkbox"/> Physician	<input type="checkbox"/> Discharge Planner	<input type="checkbox"/> Nursing Home
	<input type="checkbox"/> Home Health	<input type="checkbox"/> Other:	

**We will contact patients within 24 hours to schedule their appointment.  
Thank you for your continued support and trusting us with your patients.**



Download, Complete and  
Fax New Patient Referral  
Form to (912) 304-5624



Call our New  
Patient Coordinator  
at (912) 348-3818



Email form to:  
referrals@jointpainmds.com



Complete a referral order  
using Leading Reach™

PLEASE INCLUDE ALL RELEVANT MEDICAL RECORD PROGRESS NOTES WITH DIAGNOSIS, LAB TESTS AND IMAGING RESULTS.

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