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:		☐ M ☐ F	
Primary Care Physician:		Phone:	
PATIENT DEMOGRAPHICS (may attach face sheet instead)			
Address:	City:	State:	Zip:
Phone:	Alternate Phone:		
PATIENT INSURANCE INFORMATION (may attach face sheet instead)			
Primary:		ID#:	Group#:
Phone:			
Secondary:		ID#:	Group#:
Phone:			

REFERRAL REASON	***Wound Location***	***Wound Size***
☐ Knee pain	☐ Frozen shoulder	☐ Rotator Cuff injury
☐ Hip pain	☐ Back pain	☐ Elbow pain
☐ Bursitis	☐ Tendonitis	☐ Degenerative Disk Disease
☐ Sciatic pain	☐ Carpal Tunnel	☐ Plantar Fascitis
☐ Other		
ADDITIONAL COMMENTS:		

Does Patient have a cardiac pacemaker/defibrillator?	☐ No ☐ Yes
Does Patient have an infusion pump?	☐ No ☐ Yes
Does Patient have a bleeding disorder?	☐ No ☐ Yes

REFERRER INFORMATION			
Name:		Phone:	Fax:
Referral Source:	☐ Physician	☐ Discharge Planner	☐ Nursing Home
	☐ Home Health	☐ 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.