Pain Management
90 Jackson Pike
Gallipolis, OH 45631
Phone: 740-446-5530; Fax: 740-446-3049

PLEASE NOTE: Medications **will NOT** be addressed on the first visit. Dr. Parekh practices interventionally and will only address medication after all other avenues have been exhausted.

Date: _____

Reason for Referral: _____

Referring Physician:_____ Phone:_____ Fax:_____

Location Preference (please circle): Gallipolis Athens

Patient Information:

Patient Name: _____ DOB:_____ Sex: M / F

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

Phone: _____ Cell/Alternate Phone:_____

Social Security Number: _____

Has the patient ever been seen by Pain Management: YES NO

If "YES", where and when? _____

Any related surgeries? YES NO

If "YES", what type of surgery, where, and when? (Please send any op notes/surgical records) _____

_____

Insurance Information – please inform us if this is a Worker's Compensation Claim (include claim information)

Primary: _____ Secondary:_____

Fax completed referral form and the information listed below to 740-446-3049. Once an appointment has been made, our office will fax this sheet to the referring provider's office with the appointment date and time.

- Patient demographic sheet
- Insurance card(s)
- Medication list
- Relevant imaging reports within the last 12 months
- Physician progress notes

**Office use only:

Appointment date: _____ Time:_____ with Dr._____