

**Tracy L. Neuendorf, D.O., F.A.O.C.A., Medical Director**  
Board Certified Pain Management & Anesthesiology



**REFERRAL FAX LINE**  
FAX: 330.629.8373  
Phone: 330.629.2888

DATE: \_\_\_\_\_ Number of Pages Faxed: \_\_\_\_\_

**PATIENT INFO:**

Patient Name: \_\_\_\_\_ DOB : \_\_\_\_\_ Soc. Sec.: \_\_\_\_\_

Phone: \_\_\_\_\_ Insurance: \_\_\_\_\_

Is this a work-related injury? \_\_\_\_\_yes \_\_\_\_\_no

Has the patient been seen in any Pain Clinic before? \_\_\_\_\_ yes \_\_\_\_\_no

If yes, Facility name: \_\_\_\_\_

Has this patient ever been dismissed by another physician? \_\_\_\_\_ yes \_\_\_\_\_ no

If yes, the Physician's name: \_\_\_\_\_

Patient's Primary Care Physician: \_\_\_\_\_

**\*Records needed if dismissed or seen by another pain physician.**

**Reports Needed for Referral For Consultation to Doctors Pain Clinic:**

*We will call your patient to schedule an appointment as soon as all the information below is received in our office.*

\_\_\_\_ Last two Progress Notes      DX: \_\_\_\_\_

\_\_\_\_ Demographic Form

\_\_\_\_ C-9 for Worker's Compensation

\_\_\_\_ Medication List

\_\_\_\_ Attach previous or recent test reports/results related to the condition (MRI, X-RAYS, CT Scans, EMGs, etc.)

**NOTE: Continuation of current oral medications is not guaranteed.**

**REFERRING PHYSICIAN INFO:**

Physician Name: \_\_\_\_\_

Office Contact for this Referral: \_\_\_\_\_ Ext \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

NPI# \_\_\_\_\_ Medicaid Billing Number: \_\_\_\_\_

UPIN# \_\_\_\_\_

**SELECT THE OFFICE LOCATION MOST CONVENIENT FOR YOUR PATIENT**      **THANK YOU FOR YOUR REFERRAL!**

**Main Office/Boardman, OHIO**  
1011 Boardman-Canfield Road  
Youngstown, OH 44512  
330.629.2888 or 1.888.784.4312

**Warren/Howland  
Hunter's Square**  
8740 E. Market Street Suite 2  
Warren, OH 44484  
330.647.6404

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