Alabama Spine and Pain
Pavan Telang, MD

541 West College Street, Suite 2000
Florence, AL 35630
Phone 256-712-2422
Fax 256-712-2377

REFERRAL FORM

PATIENT INFORMATION

FIRST NAME	MI	LAST NAME	GENDER ☐ MALE ☐ FEMALE
STREET ADDRESS			
CITY , STATE & ZIP CODE			
HOME PHONE		CELL PHONE	WORK PHONE
SOCIAL SECURITY NUMBER _____ - _____ - _____		DATE OF BIRTH (mm/dd/yyyy):	
EMAIL:			

PHYSICIAN INFORMATION

REFERRING PHYSICIAN'S NAME:	PHONE:	FAX:
PRIMARY PHYSICIAN'S NAME:	PHONE:	FAX:

REASON FOR REFERRAL / DIAGNOSIS

	□ Routine □ Urgent**

INSURANCE INFORMATION

PRIMARY INSURANCE:	POLICY #:
SECONDARY INSURANCE (if any):	POLICY #:

Please **Fax** this completed form to **256-712-2377** along with copies of the following:

- ☐ Front and back of patient's insurance card(s)
- ☐ Patient's demographic sheet (if available)
- ☐ 2-3 most recent office notes along with medication list
- ☐ Radiological reports (X-ray/MRI/CT scan) related to reason for referral
- ☐ Pain management notes from **any prior** pain management physicians
- ☐ Any other medical record applicable to patient's condition

Please allow 2 business days for our physician to review the paperwork. If we can be of service to your patient, our office will contact the patient directly to schedule an appointment.