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Board Certified Pain Management & Anesthesiology

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Board Certified Pain Management & Physical Medicine & Rehabilitation



REFERRAL FOR CONSULTATION FAX FORM

DATE: _____ Number of Pages Faxed: _____

PATIENT INFO:

Patient Name: _____ Phone: _____

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: _____

SALEM OFFICE
PHONE: 330.332.5501
330.629.2888 (Main Office)
FAX: 330.629.8373

***Records needed if dismissed or seen by another 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 pain 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# _____

Main Office/Boardman, OH
1011 Boardman-Canfield Road
Youngstown, OH 44512
330.629.2888

Warren Office
1934 Niles-Cortland Road NE, Suite B
Warren, OH 44484
330.841.4032

Salem Office
1070 East State Street
Salem, OH 44460
330.332.5501

Akron/Barberton Office
201 Fifth Street, Suite 11
Barberton, Ohio 44203
330.615.4050

Pennsylvania Office
Hermitage, PA
1005 Campus Circle Drive
Hermitage, PA 16148
1.888.784.4312

THANK YOU FOR YOUR REFERRAL!

www.doctorspainclinic.com