PAIN MODULATION ASSOCIATES™

Physician Referral Form

Please Complete All Information.

Patient's Name			*DOB*
Address	*City*	*State*	*Zip*
Home Telephone	*Work Telephone*		
Insurance	*I.D. Number*		
Primary Care Physician		*Referring Physician*	

INDICATION FOR REFERRAL: _____

☐ Worker's Compensation

Employer: _____ Date of Injury: _____

Claim Number: _____ Insurance Company: _____

Address: _____ Phone: _____

Adjuster: _____

Please Attach Most Recent: Diagnostic Exam(s) including X-Rays, MRI and/or CT Scan; History & Physical Examination including Medication, Allergy, and Problem Lists; Laboratory Tests

YOUR PATIENT WILL BE EVALUATED & TREATED BY THE PAIN MANAGEMENT CENTERS OF NEW ENGLAND PHYSICIANS AND YOU WILL RECEIVE REPORTS OF THESE VISITS.

Physician Signature *Date*

Kenneth Branton, MD & George Lantz, DO

Pain Management Centers

Lahey Outpatient Center
480 Maple Street
Danvers, MA 01923

Addison Gilbert Hospital
298 Washington Street
Gloucester, MA 01930

Phone: 978.304.8601 Fax: 978-462-0921

www.PainModulationAssociates.com