McFarland Clinic

Physical Medicine & Rehab/Pain Clinic Referral Form

1015 Duff Ave, Ames, IA 50010
515-956-4077 Fax: 515-239-4758

Form must be filled out completely *Fax 515-239-4758*

Referral Date: ____________________ Referral Diagnosis: ______________________________________

Patient Name: ____ MRN: *(internal)* _____________

Address: ____ DOB: ________________ Age: ____

City, State, Zip: ____ Phone #: ____________________

Referring Physician: _________________________________ Specialty: _________________________

Address: ____ NPI #: _______________________

Referring Physician Phone: _________________________________ Fax: ________________________

Contact Person to Schedule appointment ____

Phone: ________________________ Relationship:____________________

- Has this patient been evaluated by a Pain Specialist? Yes No
  - If yes, please send **PM&R/Pain clinic records** including clinical notes and **test results** including reports.
    (e.g. CT's, MRI's, EMG/NCV, etc). Please have patient bring pertinent imaging on disc.
- Interpreter Needed? ____Yes ____No If Yes, what language___________________________
- Is this Work Comp? ____Yes ____No
  - If Yes, send all work comp billing information with approval by case manager to be seen by PM&R/Pain clinic.

CLINICAL QUESTION TO BE ANSWERED:*(Please include specific symptoms and diagnosis)*

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Check mark all records sent (All information is needed to schedule appointment)

- ❏ *Patient demographics and insurance cards (front and back)*
- ❏ *Clinic Notes, Hospital/ER notes*
- ❏ *Previous PM&R/ Pain clinic records*
- ❏ *Medication List*
- ❏ *MRI/CT reports (Images required)MUST have MRI/CT images for appt*
- ❏ *Care EveryWhere access given _____Yes _____ No*
- ❏ *MRI/CT Images pushed to McFarland _____Yes _____No*

Thank you for your referral to McFarland Physical Medicine and Rehab Department

Form Revised 8/1/19