CAROLINAS PAIN INSTITUTE
EXPERTISE. ANSWERS.

Carolinas Pain Institute, PA
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PATIENT REFERRAL FORM – CHARLOTTE

Please complete the following options:

DR. CAREY-WALTER CLOSSON

FIRST AVAILABLE

1. Patient Demographic Information

Patient name: ____
Street address: ____
City: ______________________ State: __________ Zip: ____________

Phone number: ________________ Alternate phone number: ____________________
DOB: __________________ SSN: __________________________

Patient's employer: ____
Patient's primary care physician: __________________________________
Patient's Primary Insurance: ______________________________________
Patient's Secondary Insurance (if any): _____________________________

2. Referring Provider

Referring physician: ____
Office address, city, state, zip code: _______________________________
Office phone number:________________________ Fax: __________________
Office contact person: ____

3. Referral Criteria

What service would you like us to provide to your patient? Please check one:

__ Consideration for the following procedure:
__ Consultation with recommendations made for pain management
__ Evaluate and assume responsibility for pain management

4. Medical Imaging and required documents:

Please fax this completed form to the fax number listed above, along with:

__ Copy of patient's insurance card(s) **(Front and back copy is required before referral is reviewed)**
__ Copies of 2-3 most recent office notes
__ Copies of any X-ray/MRI/CT reports relating to the patient's pain symptoms

Once received, please allow up to ***10 business days*** *for our physicians to review. Once approved, our staff will contact the patient directly to schedule an appointment. If we are not able to provide services to your patient, a staff member will notify your office as soon as possible. Thank you!*

Additional Questions? Please contact NP REFERRAL COORDINATOR 336-765-6181 ext 133/ext 288