



Pain Management Specialists **Of Atlanta**

FAX REFERRAL TO: 770-389-5947

Randall C. Berinhout, M.D.
Pickens A. Patterson III, M.D.

Date: _____

Physician/Practice Information

Referring Provider Name (First & Last Name, Credentials) and Address:

(*If there are multiple offices, please list only the office from which the patient is being referred.)

Phone: _____ **Fax:** _____

Patient Information

Patient Name: _____

Home Phone: _____

Work/Cell: _____

Reason for Referral

Diagnosis: _____

Evaluate & Treat

Procedure Only (Please list procedure and attach order.)

Nerve Conduction/EMG Study: Upper Lower Both

Other: _____

Please send copies of any pertinent office notes, test results and insurance information.