 **RESTORATION HEALTH**

**Clay Rainer, lV, MD \* David Thomason, MD**

**Celeste Fleming, PA-C \* Ashley Greer, PA-C \* Stefanie Miller, CRNP**

**(P) 251-626-0732 (F) 251-272-1983 restorationdocs.com**

 **Referral Form**

**Date of Referral**: **Dr. Rainer Dr. Thomason Next Available**

 **Referral Source**

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| --- |
| **Physician/Practice:**  |

**Phone: Fax:**

**Email:**

 **Patient Information *(Please send a demographic sheet with patient's insurance information)***

**Name: DOB:**

**Phone: Alt#:**

 **Reason for Referral & Additional Information**

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| --- |
| **Neck Pain \_\_\_\_\_\_ Mid Back Pain \_\_\_\_\_\_ Low Back Pain \_\_\_\_\_\_****Joint Pain \_\_\_\_\_\_ (please specify) Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Does the patient have any X-rays, MRIs, CTs, etc. of the area?**  **Yes \_\_\_\_\_ No\_\_\_\_\_\_****If yes, what facility?** **\*\*\**patient will need to bring a disc copy*\*\*\*** |
| **History of any prior treatment to the area? (surgeries, epidurals, pain mgmt, PT, etc.)**  **Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_****If yes, please explain:** |

\*\*Please inform your patient that ***ALL*** records will be reviewed prior to scheduling an appointment\*\*

Please fax this form, most recent office notes, medication list, demographics and any imaging reports to ***(251) 216-4343.***

Our New Patient Coordinator, Tonya, will contact the patient and schedule an appointment to best suit the patient's availability. Once the appointment is scheduled, Tonya will contact the referring Physician's office with the appointment information.

\*\*\*Appt. scheduled for at with in our ***Spanish Fort/Foley*** office. Patient has been informed.\*\*\*