HAYSMED

Pain Center

Request for Consultation, New Patient, or Self Referral

2500 Canterbury Drive, Suite 206 | Hays, KS 67601 | 785.623.5940 | FAX 785.623.5680

❑ *Consultation* ❑ *New Patient/Self Referral*

Patient Name:_____ Date:_____

DOB:_____ SSN:_____

Phone Numbers Home:_____ Cell:_____ Work:_____

Address: _____

City State Zip Code

Requesting Physician:_____

Physician's Address:_____

City State Zip Code

Phone:_____ Fax:_____

Insurance:_____ Injury Date:_____

Responsible Party:_____

Requested Physician:_____ or ❑ First Available

Reason for Consultation:

_____

_____

Is the patient a Veteran? ❑ Yes ❑ No If yes, has a request of service (ROS) been sent? ❑ Yes ❑ No

Is this complaint work related? ❑ Yes ❑ No

- If this complaint is work related, please ask the patient to provide us with a copy of the first "Report of Injury" submitted to their employer at the time of their appointment.
- If the patient's insurance requires a primary care referral for specialty care, (example: HMO) please fax it to (785) 623-5680 in advance of their appointment.
- If you would like to be notified of the appointment time, please complete the following information.

Contact Person:_____ Contact #:_____ ❑ Phone ❑ Fax

Clinics: Please fax the following information with completed form

❑ Demographics
❑ Insurance
❑ History and Physical
❑ Current and Complete Medication List
❑ Lab Reports (pertinent to current referral issue)
❑ Imaging Reports (pertinent to current referral issue)
❑ Pathology Reports (pertinent to current referral issue)
❑ Cloud images to HaysMed if applicable

_____ _____

Signature of Person Completing Form **Date/Time**

Form # CLI 840 Revised 4/25

DOB: D A/Sdt: