Essential Sports + Spine Solutions

Interventional Pain Management

Referring Physician: _____ Date: _____

Referring Office Phone #: _____ Fax #: _____

Patient Name: _____ DOB: _____

Sex: M F Other: _____

Address: _____

City, State, Zip: _____

Patient's email address:_____

Home Phone #: _____ Mobile Phone #: _____

Primary Insurance: _____

Does insurance require a referral? Yes / No (If yes, please attach a copy of referral)

Subscriber ID Number: _____

Subscriber Name & DOB:_____ (if different than the patient)

Secondary Insurance: _____

Subscriber ID Number: _____

Subscriber Name & DOB:_____ (if different than the patient)

Location to be seen:

6100 East Main Street #107
Columbus, OH 43213

402 South State Street
Marion, OH 43302

Patient agrees to accepts text messages/phone calls to the provided mobile phone number regarding information on scheduling their appointment

Yes No

Reason For Referral (Diagnosis, Symptoms, or procedure):

_____

Please Fax to 833-921-2126

If possible, please send the following information with your completed referral:
Copy of the patient's insurance card (front and back) – card must be legible
Any relevant medical records and x-ray reports, CT reports, MRI reports, etc.

For questions or to reach our central scheduling department directly, please call 614-626-8707
Please see our website at www.essentialsportsspine.com for more information