Anesthesia Pain Management Services

P.O. Box 299 / Manchester, TN 37349
2345 Murfreesboro Hwy. / Manchester, TN 37355
Phone: (931) 728-5607 Fax: (931) 728-8354

REQUEST FOR PAIN MANAGEMENT EVALUATION & TREATMENT

James R. Nunley, DO ***Marshall S. Millman, MD*** ***C. Robert Harmuth, MD*** ***J. Stuart Slaven, MD***

- To expedite processing, please ***fax*** *this form and* ***all*** *documentation* to: **931-728-8354**

Date:_____
Patient Name:_____
Patient Mailing Address:_____
DOB:_____ Patient Phone #:_____
SS#:_____ Alt./Work Phone #:_____

Please fax a copy of insurance card front and back.*
Insurance Co. Name:_____ Pt. ID#:_____
Insurance Co Phone #:_____
PCP Authorization Needed?_____ (If Authorization is needed, please fax)

Workers Comp. _____ Address:_____
Case Worker:_____ Employer at the time of Injury:_____
Phone #: _____ Ext._____ Fax #:_____ Date of Injury:_____

**** The following documentations are necessary prior to scheduling. Please fax (as applicable):***

☐ This *completed* form	☐ MRI Reports	☐ EMG/Nerve Cond.
☐ Insurance Information	☐ CT Reports	☐ Pain Clinic Notes
☐ Copy of Insurance Card	☐ Operative Reports	☐ Injections
☐ H&P	☐ Progress Notes	☐ Myelograms
☐ Previous TX	☐ Lab Reports	☐ Current Medications
☐ Referral/Authorization	☐ X-Ray Reports	☐ Other

*To avoid delays in scheduling your patient, please provide **all** applicable records. *(Please do not submit actual films.)*
*****If current diagnostics are not available, *please schedule these in advance*.

Diagnosis: _____
Has patient ever been to another pain clinic?_____
If yes, Where?_____
Reason for leaving_____
Referring Physician_____ Phone_____
Address_____ City_____ State_____
UPIN#:_____ NPI#_____ Fax#:_____
Office Contact:_____ Primary Care Physician/Specialist_____

When all information is received and approved by our physician, we will contact the patient with an appointment date and will also confirm this status with the referring physician's office.

We thank you kindly for your referral!