

OMEGA PAIN MANAGEMENT



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REFERRAL FORM

Date _____ / _____ / _____

Contact _____

Referring Provider _____

NPI _____

Clinic address _____

Phone (_____) _____

Fax (_____) _____

Patient Name _____

DOB _____ / _____ / _____

Patient SS # _____ - _____ - _____

Diagnosis: _____

Patient Home #(_____) _____ - _____

Patient Cell #(_____) _____ - _____

Pt Address _____

Insurance _____ ID # _____ Group # _____

Worker's Comp ? Contact / phone _____ Claim _____

Have you attached the following:

Please check:

- | | |
|--|--------------------------|
| Patient demographics form | <input type="checkbox"/> |
| Insurance card(s) copies (both sides) | <input type="checkbox"/> |
| Last 1-2 office notes | <input type="checkbox"/> |
| Recent Xrays/CT/MRI/surgical reports related to pain | <input type="checkbox"/> |

Please visit our website www.omegapaindoctor.com for up to date information on accepted insurances and downloadable forms.