Southern Comfort Pain & Wellness Patient Referral

Phone: 678-587-5993 **Fax: 678-587-5997**

Patient Name:____ Date:_______________________________________

Date of birth:____ SSN:____

Patient Address:____

Home phone #:_________________________ Work:_____________________________ Cell:__________________________

Insurance Type: ----- Private ----- Worker's Comp ---- Motor Vehicle Accident

Insurance Carrier- Primary ______________________ Claim #/ ID # ____

For WC or MVA Adjuster Name: ___________________________ Date of Injury or Accident: ________________________

Adjuster Phone # ____ Fax # ____

Insurance Carrier- Secondary: _____________________________ ID # ____

Chief Complaints/ Relevant History/ Requested Service ____

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Ct Scan/ MRI results for current problem:____

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Referring Physician Name: ____

Referring Physician Address: ____

Phone # ____ Fax # ____

Primary Care Physician: ____

Primary Care Address: ____

Phone # ____ Fax # _______________________________________

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Thank you for referring your patient to us, please send us all relevant notes, medications log and any radiology report with the referral.