



Craig G. Flinders, M.D.  
Lyndal E. Stoutin, M.D.

Gary Haas, D.O.  
Beth Blankenship, PA-C

Date of referral: \_\_\_\_\_ Referring Provider / Phone: \_\_\_\_\_

UPIN #: \_\_\_\_\_

NPI #: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Secondary Phone: \_\_\_\_\_

Diagnosis / Pain Condition: \_\_\_\_\_

Insurance: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Work Comp Claim #: \_\_\_\_\_ Carrier: \_\_\_\_\_

Authorization #: \_\_\_\_\_

Name/phone of person authorizing: \_\_\_\_\_

Is patient on anticoagulants? ( ) Yes ( ) No

\_\_\_ Consult only \_\_\_ Consult and, if appropriate, treat

Specific request (if applicable) \_\_\_\_\_

Please include the following information with this form:

N/A Done

- Last office note specifically related to pain
- Radiology reports
- Current list of medications and allergies, if available
- Copy of insurance cards
- Please instruct patient to bring any applicable x-ray films or MRI's

Fax this form and other documents to: (208) 746-0626

**Urgent referrals may be phoned to our physician line at (208) 748-4311**