



Fax Completed Referral Form To: (260) 748-3653

-DOCTORS OFFICE ONLY LINE: (260) 748-3652 -PATIENT PHONE: (260) 748-3650

- Daniel Roth, D.O. – Board Certified Pain Medicine/ PM&R**
- Hary Ailinani, M.D. – Board Certified Pain Medicine/ PM&R**
- Semyon Faynboym, M.D. – Board Eligible Psychiatry/Board Eligible PM**

Date: _____

Patient Name: _____ D.O.B: _____

Address: _____

Phone: (____) ____-____ Social Security #: ____-____-____

Insurance: _____

Please Be Sure To Complete the Following Patient Information:

Patient's Area of Pain: _____
Patient's Diagnosis: _____
Has Patient Participated in Recent Physical Therapy? YES or NO

- Interventional Procedures Only**
- No Opiates to be Prescribed**
- Evaluate and Treat at the Physicians Discretion**

PLEASE FAX THE FOLLOWING INFORMATION ALONG WITH THIS FORM TO: (260) 748-3653

- Recent Dictation or Office Notes
- MRI/X-Ray Reports
- Insurance Card (front and back)
- Referring Physician's Name/ Office: _____
- Return Phone: (____) ____-____ Return Fax: (____) ____-____

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For Questions Call our DOCTORS OFFICE ONLY LINE AT (260) 748-3652

We will contact your patient within 1-3 business days of receiving this fax.

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