CENTER FOR PAIN CONTROL

1235 Penn Ave, Suite 302, Wyomissing, PA 19610
Phone: 610-374-2927 - Fax: 610-374-2909

Jason T. Bundy, MD | Karen A. Kerns, PA-C | Nicole L. Harper, PA-C | April E. Palmer, NP-C | Martha Decembrino, RN, MAc

Date:____________

Referring Physician:_________________________________NPI: ________________________

Primary Care Physician:_____________________________NPI: ________________________

Patient Name:____ ☐ Male ☐ Female

DOB: _____________________________

Phone#:___________________________ Cell phone#:_______________________________

Address:__________________________

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Insurance Plan:____________________

Member Id#_______________________ Group#:_________________________________

Chief Complaint:____

Diagnosis:____

Specific Requests

☐ Medication Review/Recommendation: ____

☐ Interventional Procedure: ____

☐ Other: ____

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Please fax request to **610-374-2909**. We will mail the patient their appointment date and time. We will fax back this form to referring office with appointment date.

We request that you fax along any patient information that you have.
At the minimum we need:

- **A copy of insurance card (front and back side)**
- **Demographics**
- Recent office notes
- MRI/CT/XRAY reports
- EMG's
- Operative Notes from related surgeries

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Appointment Date:______________________ Time:______________________