



# Complete Spine and Pain Care

...helping you return to you!

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Phone: (508) 665-4344 Fax: (508) 665-4355

## CONSULTATION REQUEST FORM - Fax to (508) 665-4355

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Patient's Address: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_  
Primary Care Physician: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
Address: \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ email: \_\_\_\_\_

### Patient's Insurance

Name of Insurance: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Does patient have secondary insurance?: \_\_\_\_\_ Policy #: \_\_\_\_\_  
Workman's Comp Claim #: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
Date of Injury: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Name/Address for billing: \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
We do not accept motor vehicle accidents

### Requesting Physician

Name: \_\_\_\_\_ Are you patient's PCP? \_\_\_ yes \_\_\_ no  
Address: \_\_\_\_\_ Office Phone: (\_\_\_\_) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Office Fax: (\_\_\_\_) \_\_\_\_\_  
NPI #: \_\_\_\_\_ email: \_\_\_\_\_

Patient Preliminary Diagnosis/Indication for Procedure: \_\_\_\_\_  
Specific Concern/s: \_\_\_\_\_  
Duration of Symptoms: \_\_\_\_\_  
Relevant History: \_\_\_\_\_  
Current Medications (include all anti-coagulants): \_\_\_\_\_  
Allergies: \_\_\_\_\_

Type of Request: \_\_\_\_\_ Consult  
\_\_\_\_\_ Opioid Evaluation / Comments: \_\_\_\_\_  
\_\_\_\_\_ Evaluation and treatment  
\_\_\_\_\_ Injection / Procedure: \_\_\_\_\_

**PLEASE FAX ALL IMAGING REPORTS & YOUR MOST RECENT OFFICE NOTE TO (508) 665-4355**

MD Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_