REFERRAL ORDER FORM
Interventional Spine & Pain Management

TEL: 623.777.4747
FAX: 623.777.4748

NOVASPINE PAIN INSTITUTE

Please complete form and fax to preferred location. *Thank you for trusting us with the care of your patients.* For **URGENT** referrals or questions, please email: contact@novaspine.net

A. REFERRING PHYSICIAN INFORMATION

Referring Physician:_____ NPI:_____

Contact Person:_____ Phone:_____ Email:_____

Physician Signature (if using form as order): _____

B. REFERRAL INFORMATION FOR NOVASPINE PAIN INSTITUTE TAX ID: 46-4697995 NPI: 1154745263

Appointment Type:
- ☐ New
- ☐ Established
- ☐ Injection ONLY

Location:
(Provider's vary by location, If referring to a specific provider please select by Doctor)
- ☐ Sun City
- ☐ Sun City West
- ☐ Glendale

Time Requested:
- ☐ Within 1 week
- ☐ First available
- ☐ STAT appointment

Doctor (Optional)**:**
- ☐ Clifford Baker, MD
- ☐ John Paul Malayil, MD
- ☐ Jae H. Park, MD
- ☐ Next Available/Any

C. PATIENT INFORMATION

Patient Name:_____ DOB: _____

Phone: (H)_____ (C)_____ ✉ _____

Address:_____

City:_____ State:_____ ZIP Code: _____

Reason for Visit/Diagnosis: _____

D. INSURANCE INFORMATION

Primary Insurance:_____ ID #: _____

Secondary Insurance:_____ ID #: _____

Cardholder's Name:_____ DOB:_____

If a patient's insurance requires a referral, please note that we will need to have the referral from your office prior to seeing the patient. Please include any applicable clinical notes, imaging, labs, and reports as well. Thank you.