



PATIENT REFERRAL

Patient Name: _____ **Date:** _____

Patient Phone #(s): _____ **DOB:** _____

Patient's Insurance Carrier: _____

**If available, please also fax your patient's demographics sheet.
It is not necessary to fax patient's medical records at this time.**

_____ **Comprehensive Behavioral Pain Management Program**
(Evaluation and Treatment)

Includes Behavioral Pain Management, Physical Therapy, and Medication Management

_____ **Individual Evaluation and Treatment**

_____ Individual Behavioral Pain Management Psychological Services and/or
Behavioral Pain Management/Stress Management Course

Patient Diagnosis: _____ **ICD-9:** _____

Physician's Name: _____

Physician's Phone _____ **Fax #** _____

Physician's Signature: _____

Comments _____

Please have the referring physician sign and fax to our office. **Thank you for this referral.**

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