Lisa Barr, MD
Kiersten Mills, PA-C

Barr Center
for Innovative Pain & Regenerative Therapies

933 First Colonial Rd. Suite 200
Virginia Beach,VA 23454
P: (757) 578-2260
Opt. #2 for Immediate Assistance
F: (757) 578-2261

Patient Referral

(Please Print)

www.Barrcenter.com

Patient Name: _____ DOB: _____/_____/_____ Date of Injury/Illness: _____/_____/_____

Home Ph:(_____) _____-_____ Cell: (_____) _____-_____ Work: (_____) _____-_____

Address: _____ City: _____ State: _____ Zip: _____

Patient Email: _____

Referring Provider: _____ Office Ph: (_____) _____-_____ Fax #: (_____) _____-_____

BILLING INFORMATION

We Must Have This Information To Schedule Patient

WE WILL BE FILING:

___ **PRIVATE HEALTH INSURANCE**

Name: _____ Member ID: _____ Group #: _____

Subscriber Name: _____ DOB: _____ / _____ / _____

Sex: M / F

____ **WORKERS' COMPENSATION**

Carrier / Insurance Name: _____ Claim #: _____

Claim Address: DOI: _____ / _____ / _____ Adjuster's Name: _____ Phone: (_____) _____ - _____

DOI: _____ / _____ / _____

TYPE OF TREATMENT:

Consultation / Treatment / Testing

___ Physiatry Consultation / Treatment

Procedure

___ Epidural Steroid Injection ___Cervical ___Lumbar ____Left ____Right ____Bilateral Levels:_____

___ Sacroiliac Joint Injection: ___ Left ___Right ___Bilateral

___ Hip Injection (Under fluoroscope) ___ Left ___Right ___Bilateral

___ Facet/MBB Injection ___Cervical ___Lumbar ___Left ___Right ____Bilateral Levels: _____

___ Spinal Cord Stimulator Trial Area:_____

___ Diagnostic Ultrasound Guided Injection Area:_____

Regenerative Medicine(Requires Consultation): ____ Prolotherapy Area:____ Bone Marrow Aspirate: Area:____

____ Platelet Rich Plasma(PRP): Area: ____ Fat Grafting: Area: ____

PLEASE INCLUDE ALL OF THE FOLLOWING INFORMATION WITH REFERRAL:

- Insurance referral
- Copy (front & back) of insurance card
- Diagnostic testing reports (MRI is required for all procedures)
- Complete patient demographics
- Initial office note & last 3 office notes

APPOINTMENT SCHEDULING CONFIRMATION

(This form will be faxed back to the referring provider with appointment information once appointment is scheduled)

APPOINTMENT DATE & TIME: _____ / _____ / _____ AT _____:_____

____ Attempted to contact patient 3 times without success ____ Patient declined to schedule