KRPC Referral Form

Referring Office Information

Office Contact: ____________________

Diagnosis/Reason for Visit: ____________________

Referring Physician: ____________________

Phone: ____________________ Fax: ____________________

Patient Information

Name: ____________________ Date of Birth: ____________________

Gender: __________ Best Contact Number: __________ SSN: ____________________

Address: ____________________ City: __________ State:____ Zip: ________

Insurance Information

Is the patient covered by **workers compensation**? ☐ Yes ☐ No

Primary Insurance: ____________________ Member ID: ____________________

Secondary Insurance: ____________________ Member ID: ____________________

Medicaid Carolina Access Authorization Number: ____________________

Approved Number of Visits: ____________________ Approved By: ____________________

Please including the following when faxing a referral:

- Any office notes pertaining to the reason for the referral.
- Any relevant imaging. This includes EMG results. (Please advise patients to bring a disc if there imaging was not performed at Eastern Radiology or UNC Lenoir.)
- Copy of insurance cards and a demographic sheet.

All referrals will be reviewed by a physician before the patient is scheduled. We will attempt to contact all referrals THREE times. We will contact the referring office once the patient has been scheduled, as well as notify the referring office if we were unable to contact the patient. Please call our office for all EMERGENT referrals. Thank you!

Appointment Date: ____________________ Time: ____________________

Kinston Regional Pain Center
2100 Presbyterian Lane

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