4800 Mexico Rd. Ste. 101/ St. Peters, MO 63376
Office: 636-442-5035 Fax: 636-442-5036
1055 Bowles Ave. Ste. 202 /Fenton, MO 63026
Office: 636-326-7821 Fax: 636-326-7897

PATIENT REFERRAL FORM:

Choose from one of the following options:

First Available ☐ Dr. Chad Shelton, MD ☐ Dr. Mike Boedefeld, MD ☐

1. **Patient Demographic Information**
   Patient Name:____
   Street address: _____________________________________
   City:___________________ State: ______Zip: ______________
   Phone number:______________Alternate phone number: _______________________
   DOB: ____________ SSN:___________________
   Patient's Employer: ____
   Patient's Primary Care Pphysician: ___________________________________
   Patient's Primary Insurance:____
   Patient's Secondary Insurance (if any): _________________________________

2. **Referring Provider**
   Referring physician: ____
   Office address, city, state, zip code:___________________________________
   Office phone number: ___________________________
   Fax: _____________________________
   Office contact Person:______________________________

Referral Criteria:

What service would you like us to provide to your patient? Please check one:

☐ Consideration for the following procedure

☐ Consultation with recommendations made for pain management

☐ Evaluate and assume responsibility for pain management

3. **Medical Imaging and required documents:**
   Please fax this completed form to the fax number listed above, along with:

☐ Copy of patient's insurance card(s) (Front and back copy is required before referral is reviewed)

☐ Copies of 2-3 most recent office notes

☐ Copies of any X-ray/MRI/CT reports relating to the patient's pain symptoms

~Once approved, our staff will contact the patient directly to schedule an appointment. If we are not able to provide services to your patient, a staff member will notify your office as soon as possible. Thank you!