



**Michigan  
Pain  
Specialists**

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FAX (734) 995-4366

[www.mypainmd.com](http://www.mypainmd.com)

*Main Facility:*  
3520 Green Court  
Suite 100  
Ann Arbor, MI 48105

*Satellite Facilities:*  
Woodland Health Center  
Brighton, MI 48114

**Louis D. Bojrab, M.D.**  
**John W. Chatas, M.D.**

**Edward P. Washabaugh, III, M.D.**  
**Karen M. Park, M.D.**

PATIENT'S NAME: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_  
PHONE (HOME): \_\_\_\_\_ ALT: \_\_\_\_\_  
PATIENT'S SS#: \_\_\_\_\_ DOB: \_\_\_\_\_

INSURANCE INFO:  
TYPE: \_\_\_\_\_ GROUP#: \_\_\_\_\_  
CONTRACT#: \_\_\_\_\_ PHONE: \_\_\_\_\_

AUTO/WORK COMP INFO  
ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_  
STATE: \_\_\_\_\_ PHONE: \_\_\_\_\_ ADJUSTERS NAME: \_\_\_\_\_  
CLAIM#: \_\_\_\_\_

REFERRING PHYSICIAN NAME: \_\_\_\_\_  
PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_  
UPIN#: \_\_\_\_\_ STATE LIC#: \_\_\_\_\_

PRIMARY CARE PHYSICIAN NAME: \_\_\_\_\_  
PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

CONTACT PERSON: \_\_\_\_\_ PHONE: \_\_\_\_\_

DIAGNOSIS/REASON FOR REFERRAL:

PLEASE FAX REPORTS (OFFICE NOTES, DIAGNOSTIC, MRI AND SCAN, ETC)  
TO US WITH THIS FORM

Please Note: We will make every attempt to schedule an appointment with the patient within 24 hours of receiving this completed form, along with any patient office notes, reports, etc. We will fax this form back to you after the patient has an appointment.

Appointment Date: \_\_\_\_\_ Time: \_\_\_\_\_  
Physician: \_\_\_\_\_ Location: \_\_\_\_\_

**THANK YOU FOR THE REFERRAL!**

**Please fax to Michigan Pain Specialists (734) 995-4366**