T&C Neuromax TOWN & COUNTRY

Intrathecal Pump Referral

Date of Referral:	Office Contact:
Referred by:	Phone:

Patient Information

Is it okay to contact the patient? ☐ Yes ☐ No		Social Security No.:
Patient Name:		Date of Birth:
Street Address:		
City:	State:	ZIP Code:
Phone:		Alternate Phone:

Sex:
Height:
Weight:
Allergies:

Pain Diagnosis

- ☐ Postlaminect synd-Lumbar
- ☐ Lumbago
- ☐ Chronic Pain
- ☐ Disc Degeneration
- ☐ Lumb/Lumbosac Disc Degen
- ☐ Lumbosacral Neuritis
- ☐ Other/Code

Spasticity Diagnosis

- ☐ Multiple Sclerosis
- ☐ Cerebral Palsy
- ☐ Congenital Quad
- ☐ Quadriplegia
- ☐ ABN Involun Movement
- ☐ RSD/
- ☐ Other/Code

Contact Information (if other than patient) - Contact Name:	
Relationship to Patient:	Phone:
Patient's Place of Service (if other than home): ☐ SNF ☐ ECF ☐ Rehabilitation Facility ☐ Other:	
Is the patient currently on hospice? ☐ Yes ☐ No	If yes, please proved name of Hospice Agency:
Name:	Phone:
Any other special instructions:	

Pump Related Clinical Information: Attach signed prescription, Surgical Implant Report, most recent Progress Notes, Telemetry and other relevant clinical information.

Pump Type: ☐ PCA ☐ Codman ☐ Synchromed I ☐ Synchromed II ☐ Other:	
Reservoir Capacity:	Alarm Date:
Date Pump Implanted:	Pump Medication(s):

Provider Information - Preferred Communication Method: ☐ Phone ☐ Email ☐ Fax		
Doctor Name:		NPI #:
Street Address:		
City:	State:	ZIP Code:
Phone:	Fax:	Email:

Insurance Information: Please attach a copy of insurance card, if available

Primary Plan Name:	Phone:
ID #:	Group #:
Policy Holder/Subscriber:	Subscriber's Date of Birth:
Secondary Plan Name:	Phone:
ID #:	Group #:
Policy Holder/Subscriber:	Subscriber's Date of Birth:

To ensure timely processing, please complete and attach all information.