

**DESERT PAIN MANAGEMENT**



**MAHESH KUTHURU, MD.**  
*Board Certified*

***Pain Management  
Anti Aging***

**REFERRAL FORM**

**HENDERSON** – 291 N PECOS RD STE A HENDERSON, NV 89074 (T) 702-684-6000 (F) 702-684-6002

**LAS VEGAS** – 6845 W CHARLESTON BLVD LAS VEGAS, NV 89074 (T) 702-240-8318 (F) 702-240-8331

Patient's Appointment: Time/ Day: \_\_\_\_\_ Date Referral Faxed: \_\_\_\_\_

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Referring Physician: \_\_\_\_\_ Contact Person: \_\_\_\_\_

Office Phone #: \_\_\_\_\_ Office Fax #: \_\_\_\_\_

Reason For Referral / Diagnosis: \_\_\_\_\_

Requested Procedures/Testing: \_\_\_\_\_

As Recommended by Pain Physician

Please provide the following:  Consult ♦  Evaluation & Follow-Up Care

EMG/NCS ♦  Procedures

Requested Time Frame For Care:  STAT ♦  ASAP ♦  Routine

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Patient's Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Address: \_\_\_\_\_

City / State / Zip Code: \_\_\_\_\_

Phone #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_

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Type of Insurance:  Workers' Compensation ♦  Personal Injury ♦  Other: \_\_\_\_\_

WCB# \_\_\_\_\_

Adjuster: \_\_\_\_\_

CC# \_\_\_\_\_

Body part covered \_\_\_\_\_

DOI: \_\_\_\_\_

Insurance #/ Billing Address: \_\_\_\_\_

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Primary Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_