



# Intrathecal Pump Referral

4 Creek Parkway · Suite A · Boothwyn, PA 19061  
Toll Free: (800) 223-4376 Fax: (484) 480-2252

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

**PATIENT INFORMATION:** Is it okay to contact the patient: yes no Social Security No: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

Sex:	Pain Diagnosis	Spasticity Diagnosis
<input type="checkbox"/> Male	<input type="checkbox"/> Postlaminect synd-Lumbar/722.83	<input type="checkbox"/> Multiple Sclerosis / 340
<input type="checkbox"/> Female	<input type="checkbox"/> Lumbago/724.2	<input type="checkbox"/> Cerebral Palsy / 343.9
Height _____	<input type="checkbox"/> Chronic Pain/338.4	<input type="checkbox"/> Congenital Quad / 343.2
Weight _____	<input type="checkbox"/> Disc Degeneration/722.6	<input type="checkbox"/> Quadriplegia / 344
	<input type="checkbox"/> Lumb/Lumbosac Disc Degen / 722.52	<input type="checkbox"/> ABN Involun Movement / 781
	<input type="checkbox"/> Lumbosacral Neuritis 724.4	<input type="checkbox"/> RSD / 337.2
	<input type="checkbox"/> Other/Code	<input type="checkbox"/> Other/Code:

Allergies: \_\_\_\_\_

**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 provide 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  Synchronomed I  Synchronomed II  Other: \_\_\_\_\_

Reservoir Capacity: \_\_\_\_\_ Alarm Date: \_\_\_\_\_ Date Pump Implanted: \_\_\_\_\_

Pump Medication(s): \_\_\_\_\_

**PROVIDER INFORMATION:** Preferred Communication Method: Phone Email FAX

Doctor Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

**NPI #:** \_\_\_\_\_

**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 & attach all information.**