

# REFERRAL FORM

\*You may use your own form\*

1850 Lakepointe Drive, Suite 700  
Lewisville, TX 75057

214-306-4116 | www.seva.doctor



PAIN & WELLNESS

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Phone #: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_

## Service(s) Requested

- EVALUATION FOR PAIN MANAGEMENT
- EVALUATION FOR SUBOXONE/SUBSTANCE ABUSE TREATMENT/OPIOID MISUSE
- INJECTION THERAPY: \_\_\_\_\_
- OTHER: \_\_\_\_\_

## Please Send the Following Information (If Available)

- PATIENT DEMOGRAPHICS
- PATIENT INSURANCE INFORMATION (COPY OF INSURANCE CARD)
- RECENT IMAGING REPORTS (MRI, CT, X-RAY, ETC.)
- PERSONAL INJURY OR MOTOR VEHICLE ACCIDENT (ATTACH INFORMATION)

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## FAX COMPLETED FORM TO 469-630-0069

Referring Provider/Party: \_\_\_\_\_

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

Fax: \_\_\_\_\_

**Thank you for  
referring to  
Seva Pain and Wellness**