EASTERN
Headache & Spine

Date: ___/___/____ Return Fax: (252) 215-1045

# Workmans Comp Referral Form

*Please be advised a deposit of $500 is required prior to your clients first office visit. Invoice will be sent once appointment has been scheduled and is due prior to their first visit.

Reason for referral: _____

Employee Name: _____

DOB: _____/_____/_____ SSN: _____-_____-_____

Address: _____

Phone: _____-_____-_____ Alt.: _____-_____-_____

WC only

Employer Name: _____

DOI: _____/_____/_____ Injury Site/Body Part/Covered DX: _____

Claim Number: _____ Auth Number: _____

WC Company Name: _____

Billing Address: _____

Ph: _____-_____-_____ Fax: _____-_____-_____

Case Manager:_____ Ph: _____-_____-_____ Fax: _____-_____-_____

Email: _____

Adjuster: _____ Ph: _____-_____-_____ Fax: _____-_____-_____

Email: _____

*Please Note* Relevant medical records are required prior to review! Please fill in completely and return with office notes/testing for review. If referrals are accepted our office will contact the patient to schedule.

James Bryan Cooper, M.D. * Amy Hopkins, N.P.
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