ALBEMARLE PAIN MANAGEMENT ASSOCIATES

Pain Management Associates
630 Peter Jefferson Parkway, Suite 170
Charlottesville, VA 22911

PHYSICIANS' REFERRAL PREFERENCE SHEET

Physician name: _____ Practice: _____

Preference of physician at PMA:

☐ Dr. Mark Dean ☐ Dr. Scott Chirichetti ☐ Dr. Denise Crosson

Please notify me of patient care via:

☐ Phone call ☐ Letter ☐ Please do not notify me

Please notify me of patient care:

☐ After first visit ☐ After each visit ☐ When plan-of-care is complete

The person who coordinates my referrals: _____

The person who coordinates my physicians: _____

My office manager: _____

My physician coordinator/key nurse: _____

Please use the following preference for imaging:

☐ University of Virginia ☐ Martha Jefferson ☐ No preference

Preference for physical therapy: _____ ☐ No preference

Name of doctor or practice

Preference for Neurology: _____ ☐ No preference

Name of doctor or practice

Preference for Orthopedics: _____ ☐ No preference

Name of doctor or practice

Preference for Spine Surgery: _____ ☐ No preference

Name of doctor or practice

Preference for management of Narcotics: _____

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