Request to Enroll Patient in MIBAC

To: Fax# **313-731-6770**

From: _____

Attn: MIBAC Coordinating Center

Patient's Name: _____

Patient Date of Birth (mm/dd/yyyy): _____

Patient Email (required if patient does not consent to texts/sms:

_____

Did patient consent to texts/sms: ____Yes ____No

Patient Cell # (consent required): _____

MRN: _____

Visit Clinician: _____

Please provide an email address (for you or your site) for follow-up questions: _____

NEW QUESTION: Is this the patient's first visit (with any provider) for this episode of acute back pain? _____ yes _____no

Revised 11.8.2023 dw