PHYSICIAN REFERRAL FORM

Phone: 330-834-4154
Fax: 330-834-4145

____
Date of referral

______________________________ ______________
Patient's name Birth date

______________ ____________________ ______________
Phone Work (OK to call? yes no) Cell

____
Diagnosis

____ ___________________
Referring physician Phone number

____ ___________________
Address Fax number

____
Primary care physician

Has patient been seen at any pain center before? YES NO

If yes, where: ____

Reason for referral (**required**): ____

Sent to Pain Management for:

Consultant for chronic pain medical evaluation and treatment

Consult for recommendations ONLY

Consult for injection/procedure ONLY:

Epidural series   Other treatments/injections: ________________________

Referring physicians: please attach the following:

Attached summary report: includes summary report, any diagnostic reports, and medical history.

Description of problem (cause, symptoms, treatments):

Pertinent medical history:

Diagnostic testing reports: CT Scan   X-Rays   MRI   Lab Test

Other diagnostic tests: ____

If report not available, location where testing was done: __________________________

Is Patient on Coumadin or other blood thinner?   YES   NO

If yes, reason: ____

**Workman's Comp Claim?   Authorization: YES   NO

DX Claim #ICD10 (PA#): ___________________________________

Insurance carrier (**required**): ___________________________________ Policy #: _____________

Date information received: ______________________________