

Request for Evaluation
Pain Management Center

This referral form is for evaluation or consultation only.
Please use the "Procedure-only Appointment Request" form to request a procedure.

Please note: the appointment will be made based upon the information given on this sheet. All notes and documentation that arrive with this referral will be placed on the patient's chart for review by the Pain Management Center provider.

Patient name: _____ MRN: _____ Date: _____

Patient contact phone: Work #: _____ Home #: _____

DOB: _____ - _____ - _____ SSN: _____ - _____ - _____ Insurance: _____

Is this a Worker's Compensation claim? No Yes Date of injury: _____

Worker's Compensation contact: _____ WC contact phone: _____

Are you requesting a specific provider? No Yes (specify) _____

REQUIRED INFORMATION – PLEASE COMPLETE THE SECTION BELOW

Diagnosis: _____

Symptoms: _____

Length of time symptomatic: _____

Previous surgeries/procedures (include dates): _____

Reason for request (please check one):

- Evaluation and treatment of condition.
- Evaluation of condition only, with recommendations for management. Return patient to referring office for treatment.
- Medication recommendations.
- Take over prescribing if opioids are appropriate for this patient

What specific answers or advice are you seeking from this evaluation? _____

PLEASE PRINT

Referring provider: _____ Office #: _____

Contact person: _____ Fax #: _____

Would you like notification of the appointment? No Yes