Referral Form
Phoebe Pain Management Center

MUST HAVE COPY OF PHOTO ID AND INSURANCE CARDS

Patient Name: ______________________________ Date of Birth: ________________
Social Security Number: ________________________ Phone Number: ________________
Address: ____
Insurance Type: ____

PLEASE PROVIDE WORKMAN'S COMP AUTHORIZATION FOR TREATMENT

Referring MD: ____________________ Address: ________________________________
Office Phone: ____________________ Fax: ________________

*MD Signature: ____

Diagnosis/Pain Focus: ____
Date of Onset/How many months? ________________________
Has patient seen another Pain Specialist?: ☐No ☐Yes; **Physician:** ________________
(Our MD will need the previous pain specialist's notes for review)

Reason for referral: ☐ Evaluate/Treat, take over treatment ☐ Consult/Recommendations
☐ Interventional care only *(to referring MD after treatment)*

Specify interventional care requested: ____
Other: ____

Please send: Pertinent DIAGNOSTIC REPORTS (MRI, CT, and NCV/EMG), previous treatment notes and current medication list.

After the Physician has reviewed the referral information, our office will fax back a confirmation of acceptance or denial. Patients accepted will be scheduled for an initial consultation. Further care will be determined at that time. We thank you for your referral.

Requirements for ACCEPTANCE:

1. Chronic pain, pain greater than 3 months or acute pain requiring diagnostic or interventional care.

   Please specify: ____

2. Supporting diagnostics and treatment notes
3. Previous pain management notes, if applicable
4. Copy of insurance cards and photo ID (Patients without photo ID will not be accepted)
5. Patient must not have a history of polypharmacy, substance abuse, seeking behavior or previous failure of drug screen and/or dismissal from other pain management programs for non-compliance.

Phoebe Pain Management
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