Aultman Health Foundation
Aultman Center for Pain Management
Phone 330-454-7237
FAX (330) 454-8682
Physicians Direct Line 330-580-9132

Pain Management Physician Referral Form ***Date of referral*** **_____________________**

Patient's Name__________________________________ Birth Date_____________ Patient's SSN________________

Phone____________________ Work Phone (ok to call __ y __ n)__________________ Cell Phone _______________

Diagnosis____

Referring Physician ______________________ Referring Physician Phone Number_________________________

Referring Physician Address __________________________________ Primary Care Physician _____________

Has Patient been seen in PMU before: [ ] YES [ ] NO

<u>Sent to Pain Management For:</u>

____ Consult 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):

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____

Pertinent Medical history:____

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____

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 # ICD9 (PA#) __________________________________

Insurance Carrier ____Policy #____________________________

Date information received **_________________**

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