AULTMAN
PAIN MANAGEMENT

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:

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):

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: _____