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Patient Referral Form

After receipt of your referral, we will contact your patient within 1 clinic day to arrange an appointment in our clinic. In certain circumstances, patients may benefit from a more rapid evaluation and/or treatment by one of our pain management physicians. We offer our Urgent Pain Care Promise, if requested, where your patient will be seen in our clinic within 3 working days. All such referrals are subject to approval by one of our physicians.

Date: ____/____/____

Referring Provider/Specialty: _____

Fax:(____)_____ Phone: (____)_____

Primary Care Provider: _____

Patient Name: _____

DOB: _____ Phone(s): (____)_____

Insurance: Primary: _____

Secondary: _____

Working Diagnosis _____

Urgent Pain Care requested. Indication _____

Information Needed With This Referral Form:

Patient demographics

MRI/CT/Films reports

Insurance card(s)

Copy Clinical notes

Current medications

You may contact our Patient Coordinator, Steve Poovey, with any questions or concerns at (503) 371-1010