

Referring Provider: _____ Office Phone: _____

Practice Name: _____ Fax: _____

Practice Address _____ PCP Name: _____

Patient Name: _____ MRN# _____

DOB: _____ Cell Phone _____ Home Phone _____ Work Phone _____

Mailing Address: _____

Will a supplied interpreter be needed for this appointment? ☐ No ☐ Yes Language: _____

Health Insurance: _____ Subscribers Name: _____

Policy #: _____ Group# _____ Subscribers DOB _____

Referral for the Center for Pain and Spine

Diagnosis: _____

(Please include operative/procedure notes and any pertinent imaging and imaging reports with the referral (please limit to 30 pages)

Please note, we do not take over opioid management or prescribe opioids at our facility. We will make recommendations for opioid prescribing or tapering to a referring provider.

Clinical Question You Want Answered: _____**Pertinent Image Studies:** ☐ MRI ☐ CAT Scan ☐ XRAY ☐ Other (please specify): _____**Images Studies** (images and reports) included in referral? ☐ No ☐ Yes If No, please specify where and when studies were completed: _____**Existing Implanted Devices:** _____**Are you requesting a specific provider?** If so please list here: _____**We offer a number of different services. Please choose from one of the following options:**

- ☐ **Pain Specialist Evaluation for a Non-Spine Issue** – Evaluation by a pain management specialist to include medication management or injections.
- ☐ **Pain Specialist Evaluation for a Spine Specific Diagnosis** – Evaluation by a pain management specialist to include medication management (non-opiate options), injections, Spinal Cord Stimulators, Medication pumps etc. Patient must have had an MRI within the last 12 months or a CT scan if MRI is medically contraindicated.
- ☐ **Surgical Opinion** – For patients who have failed conservative treatment and are seeking a surgical opinion for a spine complaint. Patient must have had an MRI within the last 12 months or a CT scan if MRI is medically contraindicated.
- ☐ **Screening Clinic for Spine Specific Diagnosis** – for patient without prior work-up or advanced imaging. This is a remote video or phone visit to get a patient clinically triaged by a spine provider and start a plan of care.
- ☐ **Functional Restoration Program** – Comprehensive Evaluation for patients with chronic pain lasting for more than 3 months, to assess physical capabilities, personal goals, and make recommendations for rehabilitation.