

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 Pain Clinic

What is the clinical impression and differential diagnosis? _____

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

What treatments have been tried for this problem? At what facility? _____

Pertinent Image Studies: MRI CAT Scan XRAY Other (please specify): _____

An MRI dated within one year is required for spine complaints. For non-spine related conditions, advanced imaging would expedite care. If an MRI is medically contraindicated, a CT is a reasonable alternative.

Are you requesting a specific provider? If so please list here: _____

Existing Implanted Devices: _____

We offer a number of different services. Please choose from one of the following options:

Pain Specialist Evaluation and Treatment Options: Include imaging requirements above.

Opioid Consultation

- Recommendations for opioid prescribing Guidance on weaning
- Patient has demonstrated aberrant behaviors Yes No

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 if requested.

Functional Restoration Program:

Two part assessment for patients with chronic pain lasting for more than 3 months, to assess physical capabilities, personal goals, and make recommendations for rehabilitation. Please ensure that the patient has reviewed the program on the Dartmouth website in order to fully understand what the program has to offer.

Referring Provider's Signature _____ Date _____