Dartmouth Health

Dartmouth Hitchcock Medical Center

Phone: (603) 650-2225
Fax: (603) 676-4080
Medically Urgent Fax: (603) 640-1909

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 _____

Please include patient's health insurance demographics sheet.

Referral for Pain Clinic

What is the clinical impression and differential diagnosis? _____

What work-up has been done? _____

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

(Please include operative/procedure notes and any pertinent imaging and reports with the referral (please limit to 30 pages). Please complete this form fully to prevent delay in care.

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 dedicated CT is a reasonable alternative.

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 and Treatment Options:** Include imaging requirements above.

❑ **Opioid Consultation**

- ❑ Recommendations for opioid management
- ❑ Guidance on weaning
  - ❑ History of behavioral concerns? ❑ 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**:

Enrollment is for patients with chronic pain and determined by an assessment of physical capabilities and personal goals. Please ensure that the referring provider and the patient have reviewed the program on the Dartmouth Health website in order to explore what the program has to offer.

Referring Provider's Signature _____ Date_____