Pain Management Referral Form

Patient name_____date_____
Claim #_____Date of injury_____employer_____

Referring Physician/Healthcare provider_____
Complete address_____
Telephone/e-mail_____

Reason for Referral_____
Pain Diagnoses_____
_____
Other Diagnoses_____
Pain Surgeries _____
Current Medications_____
_____

Treatments attempted without enduring success

____ comprehensive, in-patient pain management services **are not** available in this region
____ exercise/PT
____ opiate management/detoxification
____ weight loss
____ counseling
____ pain modalities (ie., TPIs, TENS, ES, heat , ice)
____ polypharmacy
____ surgery
____ regional anesthesia (epidural/other blocks)
____ out-patient efforts have failed to improve condition
____ other treatments_____

Symptom development

____ depression
____ spread of pain (location and/or intensity)
____ opiate dependence/abuse/addiction
____ weight problems
____ physical atrophy/weakness
____ impaired ADL's
____ unemployment
____ social impairment/isolation
____ stress disorder
____ hyperesthesia
____ allodynia
____ other _____

Signature_____date_____

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