# Comprehensive Pain Management

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## Pain Management Referral Form

Thank you for the referral of your patient. Please complete the information listed below, and fax this referral form back to (517)347-8287. We will contact the patient and schedule them for an initial consultation. We will then fax you the notes as they are available.

Date:_____ Referring Physician:_____

Patient's Name:_____D.O.B:_____

Address:_____

City:_____ State:_____Zip:_____

Home Phone:_____Work/Cell Phone:_____

Insurance Info--Primary:_____ Secondary:_____

Briefly describe symptoms and diagnostic impressions:

_____

REQUEST (please check the box that applies):

☐ Consultation:
- ___ Provide opinion/advice regarding the E and M of the patient's condition including treatment, diagnostic and therapeutic measures.
- ___ Call and discuss opinion/advice regarding the E and M of the patient's condition

☐ Please consider:

Diagnostic
- ___ Neural Scan
- ___ EMG/NCV
- ___ Balance Screening
- ___ VNG (Video Nystagmogram)
- ___ Discography

Therapeutic
- ___ Acupuncture/Related Therapies
- ___ Laser Acupuncture
- ___ Balance/Fall Prevention Therapy
- ___ Nerve Block Therapy
  - ☐ Epidural Steroid Injection
  - ☐ Facet Block/Sacroiliac Joint injection (___consider rhizotomy )
  - ☐ Sympathetic Block
- ___ Spinal Physical Therapy/Rehabilitation
- ___ Spinal Cord Stimulator Trial

**REFERRING PHYSICIAN'S SIGNATURE_____DATE_____**

**Please fax recent diagnostic studies (X-rays, MRI, etc.) if available.**

Referring Physician:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone:_____Fax:_____

MI License #:_____NPI #:_____