**Pain Clinic Referral Form**

Date:___________________

Request for: ☐ Evaluation with recommendations
☐ Evaluation and Treatment
☐ Medication Management
☐ Interventional/Procedure/Injection

Referring Physician:_____________________________________________________

Referring Phone/Fax:_____________________________________________________

Patient Name: __________________________________________DOB:____________

Patient Phone Number:___________________________________________________

Reason to be seen:_______________________________________________________

Diagnosis:_____________________________________________________________

Referring Office Contact Person:___________________________________________

☐ Interpreter needed? Yes: Language_________________________ ☐ No

Work Comp? ☐ Yes ☐ No Personal Injury/MVA? ☐ Yes ☐ No

Have they seen a pain clinic in the past? ☐ Yes ☐ No

Please include the following supporting documents *if applicable*.

| | | |
|---|---|---|
| Demographics | CT Report | Physical Therapy Notes |
| Insurance Info | EMG Report | Past Pain Clinic Notes |
| MRI Report | Clinic Notes | Work Comp Approval |
| X-ray Report | Medication List | |

Additional Information:___________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

Fax form and supporting documents to 515-457-9180.

Central States Pain Clinic 2425 Westown Pkwy, Suite 100 West Des Moines, IA 50266 P: 515-267-1819 F: 515-457-9180 www.centralstatespainclinic.com