W.C. PAIN MANAGEMENT
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PAIN MANAGEMENT REFERRAL

PATIENT NAME: _____ DATE OF BIRTH: _____

PRIMARY CARE PHYSICIAN: _____, MD OR DO

REASON FOR REFERRAL:

_____

_____

DIAGNOSTIC STUDIES:

CT: _____ (ANATOMY VIEWED) _____ (DATE)

MRI: _____ (ANATOMY VIEWED) _____ (DATE)

XRAY: _____ (ANATOMY VIEWED) _____ (DATE)

OTHER: _____ _____ (DATE)

****PLEASE INCLUDE THE REPORTS OF ANY PERTINENT LABS AND STUDIES WITH THIS REFERRAL.**

CURRENT MEDICATIONS: PLEASE INCLUDE DOSAGE AND FREQUENCY OR CURRENT MEDICATION LIST.

_____

_____

_____

ALLERGIES: _____

PLEASE INCLUDE THE ABOVEMENTIONED
AND **PATIENT DEMOGRAPHICS** IN ADDITION TO PHYSICIAN NOTES WHEN SENDING RECORDS FOR YOUR REFERRAL. THANK YOU.

PHYSICIAN SIGNATURE (REQUIRED): _____

DATE REFERRAL SENT: _____