Pain Management
1500 Cooper St.
Fort Worth, TX 76104
682-885-7246 phone
682-885-2510 fax

Pain Management referral form

Date __________

Patient name____________________________________**DOB**__________________________

Address____

Guardian name ____

Contact numbers ____

Language preference English Spanish other_____________________________________

Referring physician______________________ phone_____________ fax____________________

Primary insurance name____

Other____

Authorization number____

Have labs and imaging been performed (related to the consulting problem)?

X-ray Yes No if yes, please specify_____________________________________

CT/MRI Yes No if yes, please specify_____________________________________

Labs Yes No if yes, please specify_____________________________________

Has the patient participated in physical therapy? Yes No

If yes, when? ____

Diagnosis/pain focus ____

Date of onset/How many months? ____

Medications/treatments prescribed ____

Significant past medical history ____

Provider(s) referred to for current problem, if applicable ___________________________

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Thank you so much for your referral.

Requirements for acceptance:

1. Chronic pain, pain greater than three months or acute pain requiring interventional care (please specify).
2. Supporting diagnostics and treatment notes.
3. Copy of insurance card.