Referral Form

- For all Referrals, please supply chart notes, including current medication list and relevant diagnostic reports.
- For "Fast-Track" procedures, please send the patient's most recent H&P along with the office notes.

1. Patient Information

Patient Name: _____

Date of Birth: _____

Patient Insurance Carrier and ID Number:

_____

_ _____

Patient Address: _____

Patient Phone:_____

2. Referring Information

Referring Provider: _____

Phone: _____

Fax: _____

Address: _____

_____

_____

Primary Provider: _____

3. Procedure Referral

☐ Epidural Steroid Injection, Level: _____

☐ Sacroiliac Joint injection

☐ Diagnostic Facet Joints, Level:_____

☐ Spinal Cord Stimulator Consult

☐ Other Spinal Interventions:_____

_____

_____

_____

_____

☐ **Referral for Pain Management Consultation**

☐ **Referral for Medication Management Consultation**

Diagnosis: ICD-10_____

☐ Consult only ☐ Consult and Treat

Provider Name: _____

Date / Time:_____

Fax Numbers:

Mt. Baker Pain Clinic Fax: (360).733.8320

Peninsula Pain Clinic Fax: (360).479.0265

Puget Sound Pain Clinic Fax: (253).983.0066