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**Pain Management Referral Form**

 **Patient Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Specific Provider Requested?** Yes No

**If yes, please circle**: Eric J. Homberg, MD Rebecca R. Desso, MD

 Brandon Sims, APN Courtney Roberson, FNP-C

 Cindy Carroll, FNP-C

**Reason for Referral: (check all that apply)**

 Cervical spine pain

 Thoracic spine pain

 Lumbar spine pain

 Joint pain. Joint: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Side \_\_\_\_\_R. \_\_\_\_\_L.

 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Services Requested:**

 Evaluation and treat, including the prescription of therapies, medications, and performance of indicated procedures.

 Evaluate and perform indicated procedures only (referring provider will continue to prescribe medication).

 Medication prescribing only, including opioid/pain and adjuvant medications.

**Is this a work-related injury?** Yes No

**Is this injury related to a MVA (motor vehicle accident)?** Yes No

**Please check any that relate to injury?**

Prior physical therapy

Imaging (x-rays, CT scans, MRIs)

Previous pain management/injections/spinal cord stimulators/pain pumps

Surgery

Currently on any chronic opioids

**The first office visit will be a consultation only. We want to assess that we can manage the patient’s needs and expectations. Therefore, NO interventions including medications or injections will be provided at the first visit until we make an assessment.**

Please fax all records, including any imaging and patient’s medication list to 731-410-2377