UC Health Pain Medicine

7759 University Dr., Suite C
West Chester, OH 45069
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INTAKE DATE:		**IDX#**	
NAME:		Primary Ins.	
ADDRESS:		Secondary Ins.	
CITY/ST/ZIP:		DOB:	
PHONE#:		SS#	
PCP		REF DR	
ADDRESS:		ADDRESS:	
CITY/ST/ZIP:		CITY/ST/ZIP:	
PHONE #		PHONE #	
FAX#		FAX#	

This section to be completed by referring physician.

REASON FOR REFERRAL: Diagnosis/Problem

REQUESTING?

- ☐ **Consult only** (Treatment recommendations only) No medications will be prescribed at the first visit.
- ☐ **Procedures** (i.e., Nerve block, Epidural Steroid Injections)
- ☐ **Evaluation & Treatment**- Medical management. Goal oriented/Patient to be released back to referring physician.

HAS THE PATIENT CONSULTED ORTHO, NEURO, P.T. OR OTHER SPECIALIST ?

IF YES, PLEASE PROVIDE CONSULT LETTERS.

WHAT DIAGNOSTIC TESTS HAVE BEEN ORDERED?

X-RAY, CT, MRI, BONE SCAN, DEXA SCAN, MYLEOGRAM, EMG, OTHER?

IF YES, PLEASE PROVIDE RESULTS.

HAS THIS PATIENT BEEN TO PREVIOUS PAIN PROGRAMS?

IF YES, WHEN AND WHERE? **PLEASE PROVIDE CONSULT.**

HAS THIS PATIENT HAD ANY SURGERIES?

IF YES, WHEN AND WHERE? **PLEASE PROVIDE OP REPORT**

Fax Referral to:

Signature: ***Charlene Glover*** **PH: (513) 475-8282 ext. 315**

Intake Coordinator **FAX: (513) 475-8283**

New Patient Referral Form