Texas Pain & Regenerative Medicine

Physician Referral

Requesting Provider

Phone # ( ) Fax # ( )

Please specifically document consultation requests in the patient's medical record. For consultation visits, we will send a complete report to the requesting provider after the patient visit.

PATIENT INFORMATION

First Name Last Name

Patient DOB

Address

City State Zip

Phone # ( ) Language (*if other than English*)

Insurance Is the injury work-related? ☐ Y ☐ N

Hx/Diagnosis

Type of pain:

- ☐ Spinal pain
  - ☐ Cervical
  - ☐ Thoracic
  - ☐ Lumbar
- ☐ Joint pain
  - ☐ Knee
  - ☐ Shoulder
  - ☐ Other

  _____
- ☐ Neuropathic pain

  _____
- ☐ Other

  _____

  _____

Reason for visit:

- ☐ Consultation only
- ☐ Consultation and treatment *(if applicable)*

Special instructions:

- ☐ First available physician
- ☐ Specific physician/location

  _____
- ☐ Procedure/treatment request

  _____
- ☐ Other

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