Bellevue Pain and Wellness

Pain Consultation Referral Form

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Patient Name____DOB_________________________

Patient Insurance____

Patient Phone Number____

Referring Physician____ Date of Referral_______________

Contact Person at Referring Office____

Referring Office Phone_______________________________________ Fax__________________________

Reason For Referral:

□ **Injection Only**

Injection type and/or level____

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□ **New Patient Evaluation -** Patient will be evaluated for multimodal pain plan.

Special Instructions (e.g. Avoid opiates, Avoid NSAIDS) ____________________________

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□ **Post-operative Medication**

□ **Known Chronic Pain for Long Term Management**

□ **Single Consultation Only**

□ **Radiofrequency Ablation for Low Back Pain**

□ **Radiofrequency Ablation for Knee Pain**

□ **Other:**

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