boston Headache Institute

boston pain care
Live again.

boston sleep care

PHYSICIAN REFERRAL

Complete this form and fax to 781.290.0720

☐ Pain Evaluation ☐ Headache ☐ Sleep Evaluation / Study

New Patient Infomation

Patient Name ______________________________

Is pain a result of a work related injury or automobile accident?
Yes ☐ No ☐

Address: ______________________________

City: ________________ State: ______ Zip: ________

Email: ______________________________

Home Phone #: ______________________________

Work Phone #: ______________________________

Date of Birth: ________________ Sex: (circle) M F

Diagnosis: ______________________________

Date of Injury: ______________________________

Precautions/Contraindications: ________________________

Patient's Chief Complaints (circle all that apply)

Pain location

1) Neck
2) Back
3) Shoulders / arms / hands
4) HIps / legs / feet
5) Fibromyalgia
6) Other ________________

____

Headaches

1) Chronic headaches
2) Migraines
3) Head Pain
4) Facial
5) Other ________________

____

Sleep

1) Excessive daytime sleepiness
2 Fatigue
3) Insomnia
4) Chronic snoring
5) Witnessed apneas
6) Restless legs
7) Frequent awakenings
8) CPAP compliance
9) Other ________________

____

Physician Information

Referring Physician: ____________________ Practice Name: ____________________

Address: ______________________________ Phone #: ________________

City: ____________________ State: ________________ Zip: __________

Primary Care Physician: ____________________ Practice Name: ____________________

Address: ______________________________ Phone #: ________________

City: ____________________ State: ________________ Zip: __________

Patient Insurance

Name of Insurance: ______________________________

Policy #: ____________________ Group: ____________________

Does patient have secondary insurance?

Please fax medical records and recent imaging

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