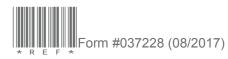
## **The Pain Medicine Center** Referral Request Form

Thank you for your interest in the Pain Center. Please provide the information requested below and fax this form to (802) 847-2965.

General Information	
Patient Name:	DOB:
Address	Phone:
Referring Physician:	Phone:
Address:	Fax:
Primary Care Physician:	Phone:
Address:	Fax:
Reason for Referral	
Include CHIEF PAIN COMPLAINT and any specific expectations from the referring physician:	
CONSULTATION FOR PATIENTS RECEIVING	G LONG TERM OPIOIDS
Because we receive many referrals for evaluation of patients taking opioid assume the role of prescribing physician for this therapy. In order to provipatient, please help us understand your area of interest by selecting from	s, we provide consultative services, but do not de meaningful assistance in caring for your
<ul> <li>Should opioids be initiated in this patient?</li> <li>Should opioids be continued in this patient? (Provide details regarding Is the patient's current medical management appropriate and can this What steps should be taken to increase patient compliance?</li> <li>How to wean the patient's opioids?</li> <li>What steps can be taken if I think my patient is abusing opioids? (province)</li> </ul>	be optimized?.

During our consultation, we will make every effort to address you specific questions, and provide our assessment and recommendations promptly. If you have any additional questions, please do not hesitate to contact our clinic to speak directly with the consulting physician at (802) 847-3737.



addiction that you have suspected or observed)



## The Pain Medicine Center Referral Request Form

We ask that the referring physician complete the itemized list below for important information that pertains to the patient and the consultation that is being requested. We do appreciate your assistance with helping us to make our consultation most beneficial for the patient.

Please check the pertinent diagnostic studies that have been completed:
<ul> <li>MRI/CT</li> <li>EMG</li> <li>BONE SCAN</li> <li>X-RAY</li> <li>INTERVENTIONAL PROCEDURES</li> </ul>
Please indicate where the reports can be reviewed:
PRISM/EMR or FAX/SCAN
Please list all specialty consultations completed for this pain complaint:
Please indicate where the consult report can be reviewed:
PRISM/EMR or via a FAX/SCAN.
THE REFERRING OFFICE IS RESPONSIBLE FOR AUTHORIZATION OF THE FIRST VISIT TO THE PAIN CENTER.
For facilitation of the approval process please check below if applicable to the patients case:
Workman's Compensation claim Motor Vehicle Accident claim.
If yes to above, please provide carrier name and contact information.
Thank you for your referral and continued efforts to provide the best health care available for our patients.

Form #037228 (08/2017)