FAULKNER HOSPITAL

Brigham and Women's Health Care

ANESTHESIA PAIN CLINIC

PAIN CLINIC REFERRAL SHEET

PLEASE COMPLETE ALL INFORMATION AND RETURN BY FAX OR MAIL:
FAX 617-983-7658 PHONE 617-983-7080

DATE: ______________________

PATIENT NAME: ______________________ DATE OF BIRTH: ______________________

ADDRESS: ______________________

CITY/TOWN: ______________________ STATE: ______ ZIP CODE: ______________

HOME TELEPHONE: ______________________ WORK TELEPHONE: ______________________

***Required Information**

INSURANCE CARRIER: ______________________ **POLICY NUMBER:** ______________

SECONDARY INSURANCE: ______________________ **POLICY NUMBER:** ______________

WORK RELATED: ❑ **YES** ❑ **NO** **INSURANCE REFERRAL NUMBER:** ______________

PCP: ______________________ **NUMBER OF VISITS:** ________ **EFFECTIVE DATES:** ______________

REFERRING PHYSICIAN: ______________________ **TELEPHONE:** ______________ **FAX:** ____________

ADDRESS: ______________________

CITY: ______________________ STATE: ______ ZIP CODE: ______________

REASON/MEDICAL NEED FOR REQUEST: ______________________

REQUEST FOR: ❑ CONSULTATION AND ADVISE ONLY ❑ EVALUATION AND TREATMENT

DATE OF LAST PHYSICAL EXAM: ______________________

PERTINENT FINDINGS: ______________________
(copy of most recent office notes acceptable)

X-RAY/CT/MRI FINDINGS: ______________________
(photocopies of official reports preferable)

TREATMENT UTILIZED TO DATE: ______________________

1. IS PATIENT ANTICOAGULATED, TAKING ASA/NSAID, OR ANY HISTORY OF BLEEDING DISORDER? ❑ YES ❑ NO

2. IS THE PATIENT DIABETIC? ❑ YES ❑ NO INSULIN? ❑ YES ❑ NO

ADDITIONAL INFORMATION

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1153 Centre Street • Boston, MA 02130 • (617) 983-7000

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