

**PAIN CLINIC OF MONTEREY BAY, Inc.**  
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# Physician Referral Form

Date \_\_\_\_\_

**IS THIS REFERRAL URGENT** (e.g. patient with life expectancy of less than 6 months, acute RSD, or acute pain needing immediate procedure?) **Yes** \_\_\_ **No** \_\_\_

Patient Name \_\_\_\_\_ Age \_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Insurance \_\_\_\_\_

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## PROCEDURAL CONSULT SERVICE ONLY

Diagnosis \_\_\_\_\_ ICD code \_\_\_\_\_

Requested Procedure \_\_\_\_\_ CPTcode \_\_\_\_\_

Diagnostic Studies (X-Ray, MRI, CT, EMG etc; please have patient bring to 1<sup>st</sup> appt.):

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

Requesting Physician \_\_\_\_\_

Phone \_\_\_\_\_ FAX \_\_\_\_\_ DEA# \_\_\_\_\_

Authorization obtained for 1) Office visit Y \_\_\_ N \_\_\_ 2) Procedure Y \_\_\_ N \_\_\_

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## COMPREHENSIVE PAIN MANAGEMENT SERVICES

Pain Diagnosis or Brief Description of Pain Problem:

\_\_\_\_\_

Current Pain Medications:

\_\_\_\_\_

Prior interventional pain procedures: \_\_\_\_\_

Diagnostic Studies (X-Ray, MRI, CT, EMG etc; please have patient bring to 1<sup>st</sup> appt.):

1. \_\_\_\_\_ 2. \_\_\_\_\_

Authorization obtained for 1) Office evaluation Y \_\_\_ N \_\_\_

2) Psychological evaluation Y \_\_\_ N \_\_\_

Requesting Physician \_\_\_\_\_

Phone \_\_\_\_\_ FAX \_\_\_\_\_

Primary Care Provider \_\_\_\_\_

Phone \_\_\_\_\_ FAX \_\_\_\_\_