

# REFERRAL FORM

**FAX: 417-888-0189**

## REASON FOR REFERRAL

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Chronic Pain Management       | <input type="checkbox"/> Opioid Use Disorder Management (Medically Assisted Therapies) | <input type="checkbox"/> Alcohol Use Disorder Management |
| <input type="checkbox"/> Interventional Pain Procedure |  | <input type="checkbox"/> Weight Management Program       |

## PATIENT INFORMATION

Last Name \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

Date of Birth \_\_\_\_\_ Address \_\_\_\_\_

Phone \_\_\_\_\_ Additional Phone \_\_\_\_\_

Has patient been previously dismissed from a pain management clinic? If yes, please explain. YES / NO

\_\_\_\_\_  
\_\_\_\_\_

**TO AVOID A DELAY IN SCHEDULING, PLEASE FAX THE FOLLOWING TO OUR OFFICE AT 417-888-0189.**

- |   |   |
|---|---|
| <input type="checkbox"/> Referral from provider                                 | <input type="checkbox"/> Current medication list                  |
| <input type="checkbox"/> Medical records (including all images: X-ray, CT, MRI) | <input type="checkbox"/> Patient insurance cards (front and back) |

## PROVIDER INFORMATION

Referring Physician \_\_\_\_\_ Specialty \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Address \_\_\_\_\_

Point of Contact \_\_\_\_\_ Phone \_\_\_\_\_