PAIN TREATMENT CENTER
180 Sawgrass Drive Suite 210
Rochester, NY 14620
585-242-1300

New Patient Referral Form

Please fax this form to 585-473-5007. Our office responds to all referral inquiries within 24 hours of receipt. Please call the Pain Center at least 48 hours in advance with any cancellations. We appreciate your interest in our center.

GENERAL INFORMATION

Name: ____

Address: ____

Phone Number_________________________________Date of birth: _____ / _____ / _____

INSURANCE:_______________________Member or Case#_____________________

WC/MVA Carrier: ________________________ DOI: ______________________

WCB/CC# ______________________________ Phone: ______________________

Referring Physician: ____

Address: ____

Phone: ____

Primary Care Physician (if different from referring physician):

PCP: ____

Address: ____

Phone: ____

CHIEF PAIN COMPLAINTS

1. ____
2. ____
3. ____

SERVICES REQUESTED

☐ Evaluate for pain injections

☐ Evaluate for behavior modalities/ acupuncture/ combination therapies

☐ Evaluate for medication assistance ***

<u>If the patient is receiving chronic opioid therapy, please fill out the Consultation Services for Patients Receiving Chronic Opioid Therapy form below***</u>.

Consultation Services for Patients Receiving Chronic Opioid Therapy

PLEASE NOTE: So that we can complete a meaningful consultation for both you and your patient, we REQUIRE that a completed copy of this form is returned with your request for any consultation regarding chronic opioid therapy.

We aim to assist patients and their providers in understanding how and when to use opioids for the long-term treatment of chronic pain.

We are frequently asked to assist with chronic opioid therapy. Because there are so many providers requesting our consultative services, we cannot assume primary prescribing responsibility for this therapy. Nonetheless, we are here to help you. Please help us understand how we can best assist you in the care of your patient by directing our attention to one of the following areas:

□ WHAT IS THE BEST OPIOID TO USE? Is this the best drug(s) for my patient? Please assess the drug/drug combination that this patient is receiving and help me to optimize.

□ SHOULD I START OPIOIDS AT ALL? I have not yet started chronic opioid therapy. Is chronic opioid therapy appropriate for my patient?

□ SHOULD I CONTINUE OPIOIDS? I have already started chronic opioid therapy and I am uncertain that I should continue this therapy. Please assess this patient and provide feedback about use of opioids in treating her/his ongoing pain. [Please provide specific details regarding any problems with compliance.]

□ HOW CAN I WEAN THE OPIOID? I have already started chronic opioid therapy and I am uncertain if I should continue this therapy. Please assess this patient and provide feedback about use of opioids in treating her/his ongoing pain. [Please provide specific details regarding any problems with compliance.]

□ HOW CAN I IMPROVE ADHERENCE AND OUTCOME. I am starting a patient on opioids or already have a patient with possible risk factors. What are the specific steps that I can take to better insure adherence to the prescribed regimen? How can I maximize the likehood that the patient will achieve adequate gains with respect to pain relief and improved function?

□ I THINK MY PATIENT IS ADDICTED TO OPIOIDS. WHAT SHOULD I DO? I have already started chronic opioid therapy and I am concerned that my patient is showing signs of addiction. How should I proceed? [Please provide specific details regarding any signs or symptoms of addiction that you have detected or suspected.

□ Please provide non-opioid analgesic options.

Thank you for your referral. We will make every effort to directly assess your specific questions during the consultation and return our suggestions to you promptly. Please do not hesitate to call the consultant in our center directly, if you have additional questions after your patient has been evaluated.

Name of provider requesting consultation (please print):___________________________
Facsimile number of provider requesting consultation: ____________________________