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 LONG TERM OPIOIDS

Because we receive many referrals for evaluation of patients taking opioids, we provide consultative services, but do not assume the role of prescribing physician for this therapy. In order to provide meaningful assistance in caring for your patient, please help us understand your area of interest by selecting from the common topics below:

- ☐ Should opioids be initiated in this patient?
- ☐ Should opioids be continued in this patient? (Provide details regarding any problems with compliance)
- ☐ Is the patient's current medical management appropriate and can this be optimized?.
- ☐ What steps should be taken to increase patient compliance?
- ☐ How to wean the patient's opioids?
- ☐ What steps can be taken if I think my patient is abusing opioids? (provide details regarding any signs or symptoms of addiction that you have suspected or observed)

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.

THE University of Vermont MEDICAL CENTER

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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:

__ MRI/CT
__ EMG
__ BONE SCAN
__ X-RAY
__ INTERVENTIONAL PROCEDURES

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.

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Thank you for your referral and continued efforts to provide the best health care available for our patients.