

UNIVERSITY OF MARYLAND PAIN MANAGEMENT CENTER PHYSICIAN REFERRAL/REQUEST FORM

Kernan Hospital 2200 Kernan Dr. Baltimore, MD 21207

Patient Phone Line: 410 448-6824

Physician Phone Line: 410-448--6622

DATE:

From: DR. _____	Phone:	Fax:
Address:		

How did you hear about us? Circle one:

Physician Meeting/Lecture Brochure Magazine /Journal Newspaper TV Website Radio Other

Patient Information: PLEASE INDICATE IF THIS IS A CANCER PATIENT

Patient Name: _____ Patient Insurance: _____

Date of Birth: _____ Patient MRN #: _____
(Kernan or UPI # if applicable)

Home/Cell Phone #: _____ Work Phone #: _____

Referral for Pain Management Consultation : *Fax to 410-448-7150*

Diagnosis: _____

Pertinent History: _____

List Current Medications : _____

Referral for Procedure (check below): *Fax to 410-448-6796*

<input type="checkbox"/> Epidural Steroid Injection: Circle one: Lumbar Cervical Thoracic	<input type="checkbox"/> Discogram: Circle one: Cervical Lumbar Level(s): _____
<input type="checkbox"/> Lumbar Selective Nerve Root Block Level(s): _____	<input type="checkbox"/> Sacroiliac Joint Injection: Circle one: Right Left Bilateral
<input type="checkbox"/> Cervical Selective Nerve Root Block -diagnostic only Level(s): _____	<input type="checkbox"/> Other Somatic/Sympathetic Nerve Block(s) Please Specify: _____
<input type="checkbox"/> Facet Block: Circle one: Lumbar Cervical Thoracic	<input type="checkbox"/> Spinal Cord Stimulator
<input type="checkbox"/> Radiofrequency Lesioning: Circle one: Cervical Lumbar Thoracic SI Joint	<input type="checkbox"/> Peripheral Nerve Stimulator
<input type="checkbox"/> Epidural Blood Patch	<input type="checkbox"/> Intrathecal Pump Circle one: Cancer Spasticity Chronic Pain

For all requests, Please attach the following information:

- Most recent notes describing the patient's pain problem and treatments
- Diagnostic test reports i.e. X-rays/MRI/CT/Lab Tests pertinent to pain problem

Upon receipt, the patient will be contacted with an appointment date.