PUGET SOUND
PAIN CLINIC

NEW PATIENT REFERRAL FORM

Date: _____ /_____ /_____

Patient (Full Name):	Date of Birth:
Patient Phone #:	Insurance Carrier(s):
Referring Provider:	Phone / Fax:

Has patient been seen at any other pain management clinic in the last 5 years? ☐ Yes ☐ No
If yes, where?

Reason For Referral

☐ Consultation Only	☐ Evaluate & Treat	☐ Injection Therapy
☐ Medication Management	☐ Second Opinion	☐ Other (Please Comment Below)

Procedure Only (state level(s) if applicable):

Procedure Type	Level(s)	Procedure Type	Level(s)
☐ Epidural Steroid Injection (Interlaminar)		☐ Radio Frequency Ablation / Neurotomy	
☐ Epidural Steroid Injecion (Transforaminal)		☐ Sacroiliac Join Injection	
☐ Facet Injection		☐ Spinal Cord Stimulator Trial / Implant	
☐ Intrathecal Pain Pump Trial / Implant		☐ Trigger Point Injection	
☐ Medial Branch Block		☐ Other: (Please Comment Below)	

Comments:

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Tukwila - Covington - Lakewood - Silverdale

PLEASE FAX THE TWO MOST RECENT CHART NOTES, RADIOLOGY REPORTS, CURRENT MEDICATION LIST, DEMOGRAPHICS, INSURANCE INFORMATION AND ANY PREVIOUS PAIN MANAGEMENT CHART NOTES.

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