AULTMAN ALLIANCE COMMUNITY HOSPITAL

Center for Pain Medicine
John W. Hill, M.D
Board Certified in Anesthesiology & Pain Medicine

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Center for Pain Medicine Physician Referral Form

Date Referral Faxed to Center for Pain Medicine:_____

Patient's Name:_____ DOB_____ Phone_____

Patient's Address:_____ Alt Phone:_____

Patient's SSN:_____ Has patient been seen in Center before: [ ] Yes [ ] No

Diagnosis:_____

Referring Physician:_____

Referring Physician's Phone Number:_____ Referring Physician's Fax Number:_____

Sent to Center for Pain Medicine for:

_____ Consult for Chronic Pain Medical Evaluation and Treatment
_____ Consult for Injection/Procedure **ONLY**:
_____ Epidural Series _____ Other Injections:_____
_____ Management of all narcotic medications

REFERRING PHYSICIANS: Please attach the following:

_____Attached Summary Report includes SUMMARY REPORT, ANY DIAGNOSTIC REPORTS, AND MEDICAL HISTORY

OR

Description of Problem (cause, symptoms, treatments):_____
_____
_____
_____
_____

Diagnostic Testing Reports: CT Scan_____ X-rays_____ MRI____ Lab Test_____

Other Diagnostic tests:_____

If report not available, location where testing was done:_____

Workman's Compensation Claim: Authorization [ ] Yes [ ] No

DX Claim #ICD9(PA#)_____

Is Patient on Coumadin or other blood thinner? [ ]Yes [ ] No

If "Yes" Reason:_____

Insurance Carrier:_____ Policy#:_____