SPECTRUM PAIN CLINICS
~A Division of Encore Health Group~

Patient Referral Form

Date

Requesting Provider

Name: Fax #

Please specifically document consultation requests in the patient's medical record. For consultation visits, we will send a complete report to the requesting provider after the patient visit

PATIENT INFORMATION

First Name Last Name

Patient DOB

City State Zip

Phone # Is the injury work-related? ☐ Yes ☐ No

Hx/Diagnosis

Type of pain:

☐ Spinal pain

☐ Cervical ☐ Thoracic ☐ Lumbar

☐ Joint pain

☐ Knee ☐ Shoulder ☐ Other

☐ Neuropathic pain

Reason for visit:

☐ Consultation only ☐ Consultation and treatment (if applicable)

Special instructions:

☐ Procedure/treatment

Other