PATIENT'S LABEL

VCU Health Systems
MCV Hospitals and Physicians
Primary Care Resident Clinic

Pain Management Referral Form

Today's Date: ____________________

Reason for Referral: ____
____
____
____

(Note if any of the following issues are present: difficulty executing pain management regimen; multi drug classes ineffective; failure to adhere to complete plan of care, i.e. referrals, physical therapy, missing multiple appointments; evidence of substance abuse—positive urine drug testing, patient's admission, collateral information)

What goals would you like to accomplish through this referral?

- □ evaluation of escalation of c/s pain meds
- □ assess for substance abuse
- □ establish adherence to complete plan of care
- □ assist with multimodal approach to pain management
- □ other (specify)____
  ____

Please indicate which of the following has been done: (include location if not VCUHS)

CT Scan-(date)___________________ Occupational therapy-(date)_______
Physical therapy-(date) ___________ MRI of __________(date)________
Other____

Please list all Medical Conditions:

__________________________ __________________________
__________________________ __________________________
__________________________ __________________________
__________________________ __________________________

Current Medication: (including scheduled pain meds, PRN pain meds, adjusted meds & OTC meds

__________________________ __________________________
__________________________ __________________________
__________________________ __________________________
__________________________ __________________________
__________________________ __________________________

Pain management agreement: Yes______ (date signed)________ No_______

Referring Provider/Primary Care Provider: ________________________________

mw/lm/meg 02/2008