

Peninsula Pain Care

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Referral Intake Form

Date Info Received: _____

Referring Physician: _____	Phone: _____	Fax: _____
Primary Care Physician: _____	Phone: _____	Fax: _____

Patient Name: _____	DOB: _____
Medical Record Number: _____	Phone: _____
Has Patient been seen in a pain clinic in the last 3 years? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Insurance: _____	Phone: _____	
Policy #: _____	Auth #: _____	
Worker's Comp Insurance Carrier: _____	Claim Number: _____	
Adjuster's Name: _____	Date of Injury: _____	Phone Number: _____

Pain Problem: _____ _____

Significant PMH: _____	Is the patient on any blood thinners? <input type="checkbox"/> Yes <input type="checkbox"/> No
_____ _____	
Are more records available from the physician's office? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Please check which intervention or evaluation you are interested in: (please indicate level and side)	
<input type="checkbox"/> Epidural – (Cervical, Thoracic, Lumbar, Caudal, or level) _____	
<input type="checkbox"/> Selective Nerve Root Blocks: _____	
<input type="checkbox"/> Medial Branch Blocks or Facet Injections: _____	
<input type="checkbox"/> Sympathetic Blockade – Stellate vs. Lumbar? _____	
<input type="checkbox"/> Plexus blockade (Celiac, Hypogastric, Impar) _____	
<input type="checkbox"/> Neurolysis (radiofrequency ablation, alcohol, cryoablation, etc.) _____	
<input type="checkbox"/> Discography or Vertebroplasty – Which Levels? _____	
<input type="checkbox"/> Peripheral nerve block _____	
<input type="checkbox"/> Implantation (spinal cord stimulator) _____	
<input type="checkbox"/> Medication evaluation _____	
<input type="checkbox"/> Other Procedures _____	

<i>Office use only:</i>	<input type="checkbox"/> Procedure: _____	Date: _____
	<input type="checkbox"/> Medication evaluation	<input type="checkbox"/> Interdisciplinary evaluation
Request additional Medical Records? <input type="checkbox"/> Yes <input type="checkbox"/> No		