PACIFIC PAIN MANAGEMENT

JONATHAN M. BLATT, MD

PAIN MANAGEMENT REFERRAL

Date: _____

Patient Name: _____ DOB: _____

Phone: (H) _____ (W) _____ (C)_____

Appointment needed: ( ) URGENT ( ) Next Available

Insurance Plan (include copy of card): _____

Referral needed? ( ) Yes ( ) No Authorization #: _____

Referring Physician: _____ Office phone: _____

PLEASE SEE THIS PATIENT FOR:

( ) Consultation regarding injections or procedures

( ) Referred specifically for this procedure at this level: _____

( ) Consultation regarding medication management

- If you are requesting that we take over pain medication, please allow for an initial evaluation and at least two weeks to obtain all pertinent records, prior to making a prescribing decision.

Notes: _____

_____

PLEASE INCLUDE THE FOLLOWING:

- Copy of insurance card - **or** - MVA or W/C information including claim #, DOI, and adjuster
- Recent chart notes
- Related imaging
- Medication list
- Problem list

Please fax this form and patient records to 503-654-5638

Thank you very much for your referral

(503) 654-5636 phone • (503) 654-5638 fax

Milwaukie, OR 97222 • 6542 SE Lake Road, #202

Tualatin, OR 97224 • 18040 SW Lower Boones Ferry Road, #207

PRINT SEND