Pain Management referral form

Dodson Specialty Clinics
1500 Cooper St, Fourth floor
Fort Worth, TX 76104
682-885-PAIN (7246) phone • 682-885-2510 fax

Referral criteria:

1. Chronic pain (greater than 3 months) or acute pain requiring interventional care (please specify below)
2. Supporting diagnostics and clinical notes
3. Completed referral form
4. Demographics sheet
5. Copy of insurance card

Fax all requested items to 682-885-2510 to avoid delays in appointment scheduling. Thank you.

Date: _____

Patient name: _____

Date of birth: _____ Guardian: _____ Relationship: _____

Address: _____

County: _____ City: _____ State: _____ Zip: _____

Best contact number: _____ ○ Mobile ○ Phone ○ Work

Current grade level/education: _____ Language preference: ○ English ○ Spanish ○ Other: _____

Referring provider: Phone: _____ Fax: _____

Primary insurance: _____ Secondary insurance: _____

Authorization number: _____

Has a diagnostic workup been performed, (related to the referring diagnosis)? If yes, please include imaging and/or lab reports with this referral.

X-ray ○ Yes ○ No

CT / MRI ○ Yes ○ No

Labs ○ Yes ○ No

Medications that you are taking/prescribed: _____

Other treatments: _____

Has the patient participated in physical therapy? ○ Yes ○ No

If yes, please specify date(s): _____

Significant past medical history: _____

If applicable, please note other referrals related to the current pain problem.

_____

Thank you for the referral.