PAIN MANAGEMENT SERVICES REFERRAL FORM

THE BIRMINGHAM PAIN CENTER
7500 Hugh Daniel Drive, Suite 300, Birmingham, AL 35242 Phone 205.313.7246 Fax 205.939.1911

Date: _____

Referring Physician: _____ Contact Person: _____

Address _____ Phone: _____ Fax: _____

Address _____ Email: _____

Does the referring physician plan to continue pain management care for this patient? Yes No

Patient Name: _____ DOB: _____ SSN _____

Home Phone: _____ Work/Cell Phone: _____ Diagnosis: _____

Relevant Medical Records required: **Check each box as you attach copies to fax or email:**

Ins Co: _____
Name of Insured: _____
Policy #: _____
Group #: _____

- ☐ Last 4-5 Office Visit Notes (Treatment for pain)
- ☐ Demographic Information
- ☐ MRI and/or X-Ray reports if available
- ☐ Insurance Card

Pain Management Services: (Note: All Interventional Procedures are image guided.)

1 ☐ 1st Available ☐ R. Daniel Chang, M.D. ☐ Nitin Chabra, M.D. ☐ Michael Gibson, MD
2 ☐ Pain Management Consult Only **or** ☐ Complete Transfer of Pain Management Care
3 ☐ Procedure Only Which procedure? _____ **or** ☐ TBD by the BPC M.D.

Psychological Services: **Jay Heisler, Ph.D.**

☐ Counseling/Psychotherapy: ☐ Screening/Clearance for: _____
☐ General/Comprehensive Psychological Evaluation: ☐ Other (specify): _____

Patient Sections: (Signature at bottom validates the Medical Records Consent, to process referral more quickly.)

Answer each question honestly, explain "yes" answers. ***("Yes" does NOT rule out approval, but dishonesty will.)***

1 Have you ever experienced **injury** from an accident, while at work, or personal? If yes, **date of injury**: _____		
2 Are you now or have you ever been involved in **litigation (law suit)** about a medical condition?	☐ Yes	☐ No
3 Do you **plan to be involved in litigation** about a current or past medical condition?	☐ Yes	☐ No
4 Are you **being treated** for a **Work Related Injury**, whether case has settled or not, or if there is open medical coverage?	☐ Yes	☐ No
5 Are you, or have you ever been, a patient in a **Methadone Clinic**?	☐ Yes	☐ No
6 Have you ever been **diagnosed** with **Fibromyalgia**?	☐ Yes	☐ No
7 Have you ever been **dismissed** by another Pain Clinic or Pain Doctor?	☐ Yes	☐ No
Which clinic or pain doctor? _____		
8 Are you being treated for, or do you have a history of **substance abuse or addiction**?	☐ Yes	☐ No
9 Are you currently in a TASC program?	☐ Yes	☐ No

Financial Policies: ***We want to make you aware of the following policies. Please initial each box after reading.***

☐ **No-Show Fees**: The BPC will charge me for missed appointments unless I call MORE than 24 hours in advance to reschedule my appointment. Office Visits = $35 Procedure Appts = $100. These fees are not covered by insurance but will be billed directly to me.

☐ **Non-covered Services Statement:** I understand that services I receive from The BPC are performed when felt necessary for maintenance of my good health and that some services may not be covered by my insurance. I will be responsible for payment in full of all such non-covered services. The BPC will tell me the service and the charges when possible at or before the time of service, but I am still responsible to pay even if not alerted, except when covered by Medicare where an ABN is required.

☐ **Medical Records Consent:** I authorize The BPC to collect health records pertaining to my past or current health- care, including any and all health record(s), discharge summary, results and reports, images in any format, etc., from any source associated with my care, and I give permission to all sources to release information pertaining to my care to The BPC.

Signature: _____ **Date:** _____