INTEGRATED PAINCARE

20 WASHINGTON PLACE
BEDFORD, NH 03110

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www.integratedpain.net

CONSULTATION REQUEST FORM

REFERRAL: *Fast Track*: ☐

Referring Provider:_____ Date of Referral:_____ Phone:_____
Fax#:_____ e-mail:_____
In addition to above provider send Consult Note/Treatment Plan to:_____
Primary Care Physician (if different than above):_____

PATIENT:
Name: _____ Date of Birth: _____ Phone:_____
Patient has had a recent: MRI☐X-ray☐ Patient will have a copy for consult: Yes☐No☐
Primary diagnosis and/or reason for referral:_____
Comments:_____
_____

INSURANCE:
Primary Insurance:_____ Policy #:_____
Worker's Comp Claim: Yes☐No ☐ If Yes: Carrier:_____
W/C Contact #:_____

PRESCRIBING PREFERENCES:
If changes in symptom-relieving medications are recommended, would you prefer:
☐ IPC to make recommendations, but Referral team to do all prescribing
☐ IPC to "Manage" - make appropriate medication changes, provide scripts, etc..
☐ IPC Would appreciate a discussion on proposed recommendations. Phone: _____

Please include with this Consult Fax Request if available = Most recent progress notes, op report, MRI, CT Scan, (any diagnostic reports) related to the pain condition.
Facsimile: (603) 626-7247

Thank you for considering Integrated Pain care.

Integrated Pain Care Use Only

Date	Staff	Notes
Date of Appt:	Time:	❑ New Patient Packet Sent