SUMMIT PACIFIC
• MEDICAL CENTER •

Interventional Pain Referral

Phone: 360-495-5773 **Fax: 360-495-5767**

Patient Information

Height _____ Weight _____ BMI _____

Patient last name: _____ First: _____ MI ___ DOB: _____ Age: ____ Sex: _____

Patient Address: _____ City/State: _____ Zip: _____

Home #: _____ Work #: _____Cell#: _____ Email: _____

Referral Information

Referring Provider: _____ Location: _____ Office Phone: _____

Contact Name: _____ Office Fax: _____

Diagnosis: _____ ICD 10: _____

☐ **Chronic Pain (for greater than 3 months)** ☐ **Failed Conservative Measures**

Primary Insurance: _____ Coverage eligibility phone: _____

Member ID #: _____ Group #: _____ Effective Date: _____

Conditions referring for treatment:

- ☐ Cancer Pain
- ☐ Complex Regional Pain Syndrome
- ☐ Facet Joint Syndrome
- ☐ Headaches – occipital/cervicogenic/migraine
- ☐ Joint and Extremity Injuries
- ☐ Myofascial Pain Syndrome
- ☐ Spondylosis/Spondylolisthesis
- ☐ Sports Injuries
- ☐ Whiplash Injuries
- ☐ Other Post-Surgical Pain
- ☐ Peripheral Nerve Injury Pain
- ☐ Phantom Limb Pain
- ☐ Piriformis Syndrome
- ☐ Post-Spinal Surgery Pain
- ☐ Shingles
- ☐ Other _____

****Submission *must* include the following information:**

- ☐ **Patient face sheet**
- ☐ **List of current medications**
- ☐ **Surgical and medical history**
- ☐ **Recent history and physical**
- ☐ **Endoscopy Procedure reports if applicable**