University Center for Pain Management
UCPM of knoxville
reclaim relief & function

*"Accurate Diagnosis and Targeted Treatment of Pain"*

**Referral Form**

**Fax to 865-305-8695**

**Referral Date:** _____

**PLEASE SUBMIT** ☐ Demographics ☐ Recent Office Notes ☐ Relevant Imaging ☐ Insurance Cards

## REQUESTED PHYSICIAN

☐ First Available ☐ Jason M. Buehler, MD ☐ Mark B. Murray, MD

☐ Jeffrey B. Staack, MD ☐ Mathew B. Vance, MD ☐ Stephanie G. Vanterpool, MD, MBA

## PATIENT INFORMATION

Last Name First Name: DOB

Home Phone Cell Phone Email Address

**Special Considerations – Patient being treated by the following:**

☐ Blood Thinners ☐ Pacemaker/AICD ☐ Spinal Cord Stimulator ☐ Bladder Stimulator ☐ Other_____

## PAIN COMPLAINT

- ☐ Headache
- ☐ Back Pain
  - ☐ Thoracic
  - ☐ Lumbar
- ☐ Neck Pain
- ☐ Extremity Pain
- ☐ Failed Back Surgery Syndrome
- ☐ Myofascial Pain/Muscle Pain
- ☐ Abdominal Pain
- ☐ Radiculopathy (Level_____)
- ☐ Complex Regional Pain Syndrome
- ☐ Other _____

## INSURANCE INFORMATION

**PRIMARY INSURANCE**

Insurance Type _____

Insurance Carrier _____

Group # _____

ID # _____

**SECONDARY INSURANCE**

Insurance Type _____

Insurance Carrier _____

Group # _____

ID # _____

## PROCEDURE

- ☐ Epidural Steroid
- ☐ Transforaminal Epidural
- ☐ Facet Joint Injection
- ☐ Intra-articular Steroid
- ☐ Occipital Nerve Block
- ☐ SI Joint Injection
- ☐ Knee
  - ☐ Diagnostic
  - ☐ RFA
- ☐ Trigger Point Injection
- ☐ Spinal Cord Stimulation
- ☐ Other _____

## REFERRAL TYPE

☐ **Interventional Referral –** Opioid therapy will **NOT** be considered as part of evaluation

☐ **Comprehensive Referral –** Opioid therapy **MAY** be considered as part of evaluation

**Please Note: (Patients taking Benzodiazepines) – Per FDA recommendations, we do not prescribe opiates to patients currently taking benzodiazepines, therefore such patients will be considered for INTERVENTIONAL management**

## FOLLOW-UP CARE

☐ I would like to continue to manage this patient after the procedure

☐ I am referring the patient to you for long-term management

**Referring Provider** _____

Physician Name Phone No Fax No