

Industrial Medicine/Workers Compensation/Work Related Injuries

Chronic Pain Associates

Referral for Biopsychosocial/Multidisciplinary Chronic Pain Evaluation & Treatment

Referral for:

Evaluation Treatment Evaluation & Treatment Psychological Implant Clearance

Transfer of Care

Referring Physician: _____ Office location: _____ Phone # _____

Signature: _____ Date: _____

Patient Name (Last) _____ (First) _____

SS# _____ DOB _____

Claim No. _____ DOI _____ Ins. Carrier _____

PLEASE CHECK ALL THAT APPLY

- Pain which persists 6 months or more after injury or onset of symptoms***, or any pain that persists beyond the anticipated time of healing is an indication of chronic pain per ODG, ACOEM and the Medical Treatment Utilization Schedule (MTUS) and should be referred for biopsychosocial evaluation and treatment. Additional symptoms and areas of intervention inherent in chronic pain may include:
- | | |
|---|--|
| <input type="checkbox"/> Sadness/Depression | <input type="checkbox"/> Anxiety/Panic/PTSD |
| <input type="checkbox"/> Sleep complaints | <input type="checkbox"/> Somatic complaints (e.g. abdominal/bowel) |
| <input type="checkbox"/> Feelings of helplessness/hopelessness | <input type="checkbox"/> Frustration with medical care |
| <input type="checkbox"/> Increased pain behaviors | <input type="checkbox"/> Elevated stress levels |
| <input type="checkbox"/> Failure to respond to treatment/delayed recovery | <input type="checkbox"/> Frustration/Anger |
| <input type="checkbox"/> Excessive medication usage/requests | <input type="checkbox"/> Functional complaints/Disability |
| <input type="checkbox"/> Need for Medication Tapering/Detox | <input type="checkbox"/> Weight Gain/Loss |
| <input type="checkbox"/> Verbal/Physical/Mental Abuse | <input type="checkbox"/> Job dissatisfaction/Lack of support |

Fax with face sheet/PR-2/Reports to (877) 728-3404

Phone (877) 727-5974

www.painrehab.org