Pain Management Center
Westchester Medical Center
19 Bradhust Avenue, Suite 3040N
Hawthorne, NY 10532
Phone: 914.909.6416
Fax: 914.909.6417

Request for Evaluation

This referral form is for evaluation or consultation only.

Please note: the appointment will be made based upon the information given on this sheet. All notes and documentation that arrive with this referral will be placed on the patient's chart for review by the Pain Management Center provider.

Patient name: _____ MRN: _____
Patient contact phone: Work #: _____

Home #: _____ DOB: _____ - _____ - _____

SSN: _____ - _____ - _____ Insurance: _____

Is this a Worker's Compensation claim? ☐No ☐Yes Date of injury: _____

Worker's Compensation contact: _____WC contact phone: _____

REQUIRED INFORMATION – PLEASE COMPLETE THE SECTION BELOW

Diagnosis:_____

Symptoms:_____

_____

Length of time symptomatic:_____

_____

Previous surgeries/procedures (include dates): _____

_____

_____

If the patient is on Opioids, please write the medications and dosages here: _____

_____

_____

Reason for request (please check one): ☐

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☐Evaluation and treatment of condition including medication management *(please note, no prescriptions will be written on first visit)*.

☐Evaluation of condition only, with recommendations for management. Return patient to referring office for treatment.

☐Medication recommendations.

What specific answers or advice are you seeking from this evaluation?

_____

_____

_____

Referring provider: _____ Office #: _____

Contact person:_____ Fax #: _____

Would you like notification of the appointment? ☐No ☐Yes