MASSACHUSETTS GENERAL HOSPITAL

ANESTHESIA, CRITICAL CARE AND PAIN MEDICINE

Pain Management Center

Evaluation Request Form

Please fax **this form along with the last two visit notes** within the past six months to 617-726-3441. Our office responds to all referral inquiries within 48 hours of receipt. We sincerely appreciate your interest in our center.

General Information

Patient's name: ____

Address: ____

Home phone: __________________________ **Date of birth:** ______ / ______ / ______

Referring Physician: ____

Address: ____

____

Phone: ____________________________ **Fax:** _________________________________

Primary Care Physician (if different from referring physician): __________________________

Phone: ____________________________ **Fax**: _________________________________

Is this a Worker's Compensation claim? Yes: __________ **No:** ____________

Request Information

1. Chief complaint/diagnosis: ____
   Duration of symptoms: ____________________
2. Has the patient been seen by any other Pain Clinic? If so, please specify name of clinic:
   ____
3. What is your expectation from this evaluation?
   ____
4. Reason for request (please check one):
   - ○ Multidisciplinary evaluation
   - ○ Evaluation for an injection
   - ○ Medication Recommendations

Please fill in: As part of our comprehensive evaluation, we offer interventional options. We also provide an opinion or regimen for opioid management, if appropriate. However, we are unable to assume the responsibility for longitudinal prescribing or for short-term weaning of medications.

***__Please verify who will assume prescribing (if it is necessary):__ ____________________________

○ Other (please specify): _________________________________