Pain Management Referral Form

Dodson Specialty Clinic, Fourth Floor
1500 Cooper Street, Fort Worth, Texas 76104
Main Number (682) 885-PAIN (7246)
Fax Number (682) 885-2510

Referral Criteria:

1. Chronic pain (greater than 3 months) or acute pain requiring interventional care (*please specify below)*
2. Supporting diagnostics and clinical notes
3. Completed referral form
4. Demographics sheet
5. Copy of insurance card

*** Fax all requested items to (682) 885-2510 to avoid delays in appointment scheduling. Thank you.

Date: ______________________________

Patient Name: ______________________________ **Date of Birth:** ____________________

Guardian: ______________________________ Relationship: ____________________

Address: ______________________________ County: ____________________

City: ______________ State: _____ Zip: ________

Best Contact Number: ______________________________
Mobile / Home / Work

Current Grade Level / Education: ______________________________

Language Preference: English Spanish Other ______________________________

Referring Provider: ______________________________

Phone: ______________________________ Fax: ____________________

Primary Insurance Name: ______________________________

Secondary Insurance Name: ______________________________

Authorization Number: ______________________________

Referring Diagnosis/Pain Focus: ______________________________

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Date of Onset / Duration: ______________________________

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Has diagnostic work up been performed (related to referring diagnosis)?

X-Ray Yes / No If yes, please specify date(s): ______________________________

CT / MRI Yes / No If yes, please specify date(s): ______________________________

Labs Yes / No If yes, please specify date(s): ______________________________

Medications tried / prescribed: ______________________________

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Other treatments: ______________________________

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Has the patient participated in physical therapy? Yes / No

If yes, please specify date(s): ______________________________

Significant past medical history: ______________________________

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If applicable, please note other referrals made related to current pain problem. ______________________________

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Last revised 12/2018

Thank you for the referral.