



136 Sherman Avenue – Lower Level • New Haven, Connecticut 06511
 (Phone) 203-675-1199 (FAX) 203-675-0277

www.TotalPainTreatment.com

REFERRAL FOR TREATMENT

PATIENT INFORMATION	Today's Date:	Referring Physician:	Referring Physician Phone Number: ()
	Patient's Name:	Sex at Birth: <input type="checkbox"/> M <input type="checkbox"/> F	Patient's Cell Phone Number: ()
	Patient's DOB:	Patient's SSN:	Has Pt Been Treated for Pain Management Before? If so and known, where? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk
	Husky ID (9-characters):	Primary or Other Insurance:	Diagnosis(es), Areas of Pn

<p>Pertinent Patient Information (Check all that apply):</p> <ul style="list-style-type: none"> <input type="checkbox"/> Age 16-45 <input type="checkbox"/> Gender Dysmorphic <input type="checkbox"/> Hx of pre-adolescent sexual abuse <input type="checkbox"/> Hx of depression <input type="checkbox"/> Hx of ADD, OCD, bipolar disorder, schizophrenia <input type="checkbox"/> Hx of ETOH abuse <input type="checkbox"/> Hx of illegal drug use <input type="checkbox"/> Hx of prescription drug abuse <input type="checkbox"/> Hx of Delirium/Dementia <input type="checkbox"/> Hx of falls/vertigo <input type="checkbox"/> Hx of sleep apnea/respiratory insufficiency <input type="checkbox"/> Fam Hx of substance use disorder <input type="checkbox"/> Fam Hx of prescription drug abuse <input type="checkbox"/> Other: 	<p>To the extent possible, and to help ensure the best treatment outcome, the patient should be educated with respect to the following:</p> <ul style="list-style-type: none"> ✓ 1st visit will be a comprehensive exam and medical history. No meds will be prescribed at this visit. ✓ Labs will be ordered and reviewed at follow-up visit ✓ Behavioral Assessments will be administered ✓ A treatment and maintenance plan will be designed which must be followed in the best interest of the patient ✓ Patient/Provider Agreement and supplemental paperwork will be required. ✓ Patient may be discharged for violation of Agreement and/or Accepted Office Policies ✓ Urine and/or Swab Toxicology Screening will occur
---	---

Please Fax (**203-675-0277** HIPAA Secure) this referral with the following documentation:

- Your last two office visit notes dated within the previous six (6) months
- Recent diagnostic imaging reports (X-Ray, CT Scan, MRI, etc.)
- Blood work lab results within the past six months (BUN/Creat/Ast/Alt/Bili)
- ANA/RF Labs if pt rec'd dx that does not require imaging such as Fibromyalgia
- Medication list

Please note, it is this office's policy to not accept pts who are actively involved in a Methadone or Suboxone treatment program unless they are safely weaned off these medications with documentation proving as such. Special consideration must also be given on a case-by-case basis to accept patients with a Morphine Milligram Equivalent (MME) score greater than 200. If the patient's management includes the administering of both opioids and benzodiazepines, the opioids will be less than 50 MME/day. High-Risk Protocol will be instituted for those previously discharged from pain mgt or who exhibit inconsistent urine/swab results consisting of, but not limited to, increased weekly/bi-weekly visits prior to returning to a monthly visit course of care.

Referring Physician x _____ Date: _____