Choosing Health
NORTHEASTERN VERMONT REGIONAL HOSPITAL

Center for Pain Management Referral Form

Phone: (802) 748-7345 Patient Name: _____

FAX: (802) 748-7417 DOB:_____

Diagnosis:_____

Referring Physician: _____

Evaluation or Procedure Requested:_____

****Please include:**

- **Patient Demographic information & Insurance information**
- **Pertinent office notes (at least last office note documenting problem)**
- **Imaging Reports and Push Imaging through PACS**
- **Current patient medication list, problem list and Allergies**
- **Recent Labs**

Is patient on an **anticoagulant**? Yes_____ No_____

If yes, please complete Anticoagulant Information Sheet stating Patient orders and inform patient when to stop. If it is unadvisable for Patient to stop therapy, consider bridging with Lovenox.

Is patient diabetic or on metformin? **(If Yes, Include last A1C within last 3 months)**
Yes_____ No _____

Is patient **allergic** to anesthetics and/or steroids? Yes_____ No _____

If **yes**, please list medication and reaction:_____

Has the patient had any previous spinal Surgeries? Yes_____ No _____

Who was the surgeon?_____

Has patient had MRI, CT or X-Ray in the last **3 years**? Yes_____ No _____

If **YES**, where:_____

- **If no, and symptoms are radicular, please order an MRI or the affected part.**
- **If the patient cannot have an MRI, please order a CT scan of affected part.**
- **Scheduled Imaging Appointment Date and Time:_____**