SXM SYMPTOM MEDICINE
Pain Medicine, Palliative Care, Anesthesia

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PROCEDURE &ANESTHESIA REFERRAL FORM

Please inform your patient that an appointment can be scheduled when the following are complete: physician referral, insurance pre-authorization, new patient forms and medical records such an H&P, progress notes, recent labs and diagnostic reports. For urgent needs, please call the clinic for immediate advice.

Referring Physician	Phone	Date of Request
Address	Fax	Email

Patient Name	DOB / / 19	Age Male/Female
Address	Home Tel.	Cell Tel.
Primary Insurance	Number	Insurance Pre-authorization No.
Secondary Insurance	Number	

Reason for Referral	Type of Appointment	Type of Procedure Requested
☐ Acute Pain Management ☐ Cancer Pain ☐ Chronic Pain Management ☐ Anesthesia Pre-op Consult ☐ Other	☐ Routine ☐ Urgent ☐ Acute ☐ Life Expectancy <6 Months	
	Pain Location and Type	

Comments (including psychosocial or dependency issues)

Drug Sensitivities/Allergies: Yes ☐ No ☐	Anticoagulants: Yes ☐ No ☐ Type

ICD-9	Diagnosis	Medications

Referrer's Signature:	Print Name and Date
Title:	Contact Number