SXM SYMPTOM MEDICINE
Pain Medicine, Palliative Care, Anesthesia

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CONSULTATION REFERRAL FORM

Please inform your patient that an appointment will be made after insurance preauthorization has been obtained and the necessary paper work has been received (physician referral form, 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	Pt to be Seen
☐ Acute Pain Management	☐ Acute	☐ Hospital
☐ Cancer Pain &Symptoms	☐ Urgent	☐ Clinic
☐ Chronic Pain Management	☐ Life Expectancy <6 Months	☐ Home (hospice only)
☐ Hospice Consultation	☐ Routine	
☐ Medication Management	Specific Requests	
☐ Pain Procedure/Injection		
☐ Palliative Care Consultation		
☐ Symptom Management		

Comments (including psychosocial or dependency issues)

Drug Sensitivities/Allergies: Yes ☐ No ☐		Anticoagulants: Yes ☐ No ☐
ICD-9	Diagnosis	Medications

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