Pain Relief Center

Telephone (304) 757-5420

Fax (304) 757-5421

Requested Information	Completed Information
Date:	
Requesting Physician:	
Office Address:	
Office Phone / Fax Numbers:	
Patient Name:	
Date of Birth	
SS#	
Home Address:	
Home Phone Number:	
Alternate Phone Number:	
Reason for Referral: Type of Pain:	
Region of Pain:	
Requesting:	☐ Interventional Treatments ☐ Interventional Treatments and Medication Management *Has the patient had past medication compliance issues? Yes / No
Auto Accident?	Yes / No
Work Related Injury?	Yes / No
Insurance Type:	
Referral/Authorization Number:	
Workers Comp Only:	
Date of Injury	
Claim #	
Case Manager Name and Phone#:	

Please Attach and Fax:

- All pertinent medical records, including office notes, MRI's, radiology reports, and med list
- Copy of the patient's insurance card, including authorizations when applicable
- ***Note:** We specialize in interventional pain management and a new patient consultation does not guarantee medication management.