

Pain Mastery Center

Fax: 504.903.1605

Referral from: BMC EKL LJC LAK
 LIH UMC WOM Other: _____

Patient Label/Stamp

Attending Provider: _____ ID Number: _____

If Patient Label/Stamp is Not Available Complete the Following:

Patient's Name: _____ Date of Referral: ___/___/___

Date of Birth: ___/___/___ Medical Record Number: _____

1° Contact Number: _____ 2° Contact Number: _____

Email Address: _____

Pain Mastery Center Referrals provide for an evaluation of the needs of patients with chronic pain conditions. The consultation serves to assist the Primary Care Providers in meeting the needs of chronic pain patients by delineating a regimen of treatment which the Primary Care Provider will oversee. Re-evaluation by the Pain Mastery Center may be necessary if the patient's condition changes or new issues develop, although the monthly health monitoring and prescription of medications will be managed by the Primary Care Providers. Therefore all referrals to the Pain Mastery Center must have a Primary Care Provider or a simultaneous referral to Primary Care if the patient is to be treated in the Pain Mastery Center.

Please indicate reason for Referral:

- 789.0 Abdominal Pain
- Acute Musculoskeletal Pain:**
- 847.9 Back Pain
- 727.3 Bursitis
- 719.9 Joint Pain
- 729.5 Limb Pain
- 729.1 Myofascial Pain
- 723.1 Neck Pain
- 726.90 Tendonitis

- 354.0 Carpal Tunnel Syndrome
- 338 Complex Regional Pain Syndromes
- 784.0 Chronic Headache
- 625.9 Chronic Pelvic Pain

Peripheral Neuropathies:

- 250.6 Diabetic Neuropathy
- 357.9 Polyneuropathy
- 355.9 Mononeuritis
- 354.5 Mononeuritis Multiplex

- 729.2 Post-Herpetic Neuralgia
- 722.83 Post-Laminectomy Syndromes

Suspected Neuropathic Conditions:

- 729.5 Pain in Limb
- 729.2 Radiculopathy

- 355.5 Tarsal Tunnel Syndrome
- 350.1 Trigeminal Neuralgia
- 354.2 Ulnar Nerve Entrapment
- Other ICD: _____ Diagnosis: _____

Clinical History Relevant to this Referral: _____

Referring Provider's Signature: _____ ID Number: _____

Contact Number: _____ Referring Service/Clinic: _____

Fax Number: _____ Email: _____

OFFICE USE ONLY: Appointment Date: ___/___/___ Time: __:__ am/pm.

If not scheduled, Indicate Reason & Recommendation: _____

Reviewing Provider's Signature: _____ ID Number: _____

Contact Number: _____

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