PORT HURON

1221 Pine Grove, Port Huron, MI 48060
FAX to: (810) 987-1532

An appointment will not be made until ALL information below is received.

Patient Identification

Pain Service Order/ Referral Form

Last Name ______________________ First Name ______________ ☐ Male ☐ Female
Date of Birth ______________ SSN ______________
Address ______________ City ______________ State ______ Zip ______
Telephone ______________ Alternate ______________
Person to contact, if other than patient: ______________________________
Name Telephone
Insurance Information: ______________________________
Authorization/Referral Required ☐ Yes ☐ No If yes, Authorization/Referral # ______________
Referring Physician ______________ Telephone Number ______________
Primary Care Physician ______________ Telephone Number ______________
ICD10 Code & Description ______________________________
Pain Consult requested ☐ Yes ☐ No
If no, consults required (CPT Code to be performed & description) ______________

Degenerative Disc Disease		Spinal Stenosis		Pain Diagnosis by Site:	
☐ Other cervical disc degeneration, unspecified cervical region	M50.30	☐ Cervical	M48.02	☐ Cervical-Radiculitis/Neck	M54.12
☐ Thoracic	M51.34	☐ Thoracic	M48.04	☐ Cervicalgia/Neck pain	M54.2
☐ Lumbar	M51.36	☐ Lumbar	M48.06	☐ Coccyx/Coccygodynia	M53.3
		☐ Other:	M48.00	☐ Low back/lumbago	M54.5
				☐ Sacroiliac/Sacrum	M53.3
				☐ Thoracic Spine-Mid back	M54.6
Herniated Intervertebral Disc		☐ Bursitis, Hip	M70.70	Headache	
☐ Other cervical disc displacement, unspecified cervical region	M50.20 M51.24	☐ Phantom limb (syndrome)	G54.7	☐ Migraine	G43.909
☐ Thoracic	M51.26	☐ Other postherpetic nervous system involvement	B02.29	☐ Migraine- (Intractable)	G43.919
☐ Lumbar	M54.5			☐ Cluster w/Migraine (Intractable)	G44.001
☐ Lumbago (low back pain/syndrome)					
Post Laminectomy Syndrome (Failed Back)		Neuralagia:		☐ Multiple Sclerosis	G35
☐ Postlaminectomy syndrome, not elsewhere classified	M96.1	☐ Intercostal	G54.8	☐ Other	
		☐ Occipital	M54.81		
☐ Neoplasma related pain (acute) (chronic)	G89.3	☐ Post Herpetic	B02.29		
		☐ Osteoarthritis of hip, unspecified	M16.9	Radiculopathy:	
		☐ Sacroiliitis	M46.1	☐ Cervical	M54.12
		☐ Sciatica	M54.3	☐ Thoracic/Lumbar	M54.14/M54.16

Has conservative therapy & non-invasive therapy treatments (ie. rest, physical therapy, NSAID's, etc.) failed? ☐ Yes ☐ No
If received Physical therapy, please list dates of service: ______________ Where: ______________
NSAID's tried: *list drug, when used & duration*

Drug Name	When used	Duration

Physician Signature ______________________ (Required) Date/Time ______________ (Required)

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Please fax to (810) 987-1532.

Please make sure the following information accompanies this form:
- **MRI or CT Scan of the specific area**
- **Office Notes relating to specific area of pain**

If you have any questions contact Pain Services at (810) 989-3283 option 1

FOR PAIN CLINIC USE ONLY		
Appointment Date:	Appointment Made ☐	Attempts to Reach Patient:
Procedure:	Completed Boarding ☐	
Procedure Time:	Hx/Instruction Sent ☐	

Physician Order
PO, Form# 2362, 01/16