REFERRAL TO WEST COUNTY PAIN MANAGEMENT CENTER

New Patient Coordinator: 314-996-8631

Thank you for your referral to our office. In order to expedite our referral process, please complete this form and return to

FAX 314-996-8741. Thank you.

Dr. Dave **Dr. Guarino**

Referral date:_____________________ Office Contact:____Ph:_______________________
Referring
Physician:____Ph:________________________________Fax:_______________________
Primary Care
Physician:____Ph:________________________________Fax:_______________________

Patient Name:____DOB:______________________
Ph: ____Alt. Ph:____
Has patient had a PT evaluation and or been seen in Pain Clinic in the last 3 years? Yes____________No_________________________

Insurance:____(please send copies of cards)
Work's Comp. Carrier:____Claim Number:_____________________________________
Adjuster's Name:____Ph:______________________Date of Injury:_____________

Pain Problem:____

____

Significant PMH:_________________________________ Meds:____

____ ____

Referring MD Expectations:____
Will the referring physician prescribe opiates if indicated? Yes:_________________________ No:______________________________
Patient's Expectations:____

Referral Type:

- ☐ Pain Management Consultation:
  - ☐ Injection Therapy:
    - ☐ Spinal Steroid Injection
    - ☐ Sympathetic Block
    - ☐ Celiac Plexus Block
    - ☐ Vertebroplasty/Tumor Debulking/Kyphoplasty
    - ☐ Discography