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The WASHINGTON CENTER for Pain Management

We strive to deliver the highest quality, most technologically advanced, comprehensive pain management services.

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Referral: (425) 361-7324
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Patient Referral Form

Date: _____

Patient (full name): _____ Phone #: (____)_____ DOB: ____/____/____

Referring Physician: _____ Referring Physician Phone #: (____)_____

Insurance: _____ Fax #: (____)_____

Diagnosis/Condition: _____ **ICD-9 code(s):** _____

Requested Services:

❑ *Evaluate and Treat* ❑ *Second Opinion Only* ❑ *Consultation*

❑ *Medication Management* ❑ *Psychological Consultation/Cognitive Behavioral Therapy*

Procedure Only:

❑ Epidural ❑ Facet ❑ Lumbar ❑ Thoracic ❑ Cervical ❑ RF ablation

❑ Stellate ❑ Celiac plexus ❑ Peripheral nerve ❑ Lumbar sympathetic ❑ SI joint

❑ Pravocative discography ❑ Spinal cord stimulation trial ❑ Blood patch

❑ Disc nucleoplasty ❑ Other _____

❑ Urgent *(patient seen A.S.A.P. urgent attention required)*

❑ Routine appointment *(patient seen in next available time slot)*

❑ Patient/family will call to schedule appointment

Comments: _____

_____

In addition to completing this form, please include all relevant chart notes, patient history, and reason for referral. We strive to schedule a patient within 72 hours and this additional information helps ensure an expedited process. Thank you.