PAIN MEDICINE

Request for Consultation Form

Department of Anesthesia
P.O. Box 850 • Hershey, PA 17033
Phone: (717) 531-6834 Fax: (717) 531-4143

PLEASE COMPLETE FORM AND FAX WITH SUPPORTING MEDICAL RECORDS TO (717) 531-4143.

Patient Name_____ MSHMC # _____ Sex ☐ M ☐ F

Address _____

City_____ State _____ Zip _____

Home Phone _____ Social Security No. _____ D.O.B. _____

Referring Physician _____ Specialty _____

Address _____

Phone No. _____ Fax No. _____ ☐ Fax Reports To My Office

Primary Care Physician _____UPIN No. _____

Address _____

Phone No. _____ Fax No. _____

HEALTH INSURANCE INFORMATION (please complete, even if this is a No-fault or Worker's Compensation claim)

☐ Work Related Injury ☐ Automobile Accident/Injury

Primary Insurance _____

Name of Insured _____

Address _____

Rel. to Patient _____

Phone No. _____

I.D. No. _____ Group No. _____

Secondary Insurance _____

Name of Insured _____

Address _____

Rel. to Patient _____

Phone No. _____

I.D. No. _____ Group No. _____

Reason for Referral _____Procedure Evaluation _____ Stimulator/Pump implant _____Consultation for treatment options

Other_____

Narrative (please explain the essential details of the case)_____

_____

_____

We are a consulting practice. As a general rule we do not take over medication management. If there is a need for this service, please contact our office at 531-6841 to speak to one of our physicians.

Past Medical History _____

_____

Past Surgical History _____

_____

Current Medications _____

_____

Laboratory or Imaging Results _____

_____

_____ No. of pages including cover _____ Date _____

Signature of Referring Physician