



COMPREHENSIVE PAIN CENTER
3303 SW Bond Ave.
Portland, OR, 97239

Physician Referral Form

Thank you for choosing the **Comprehensive Pain Center at OHSU**. Our physicians provide consultative recommendations and treatment evaluations. If medical management or ongoing treatment is recommended, we will work collaboratively with you and any other treating providers.

PLEASE BE AWARE THAT OUR PROVIDERS WILL NOT TAKE OVER THE ROLE OF PRESCRIBING MEDICATIONS. They will make recommendations only. **We also do not prescribe medication on the initial evaluation.**

In order for your patient to obtain the most benefit from his/her initial visit, please provide the following documentation:

- 1) Completed referral form**
- 2) Progress notes**
- 3) Imaging reports (X-rays, MRIs, CTs—within the last 2 years)**
- 4) Procedure notes**
- 5) Insurance verification/authorization**

Medicaid OHP/Care Oregon/DMAP referrals require prior authorization for pain management. Regardless of code pairing: **pain clinic evaluation and treatment is specifically excluded from coverage** according to Oregon Administrative Rule 410-120-1200.

Once we receive the referral, we will complete a medical review and benefit check and then will call the patient to schedule. Please fax the completed referral form and documentation to 503-494-7635. If there are questions, please contact 503-494-7246 and ask for the new patient coordinator.

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Patient Demographics:

Name:

Address:

City/State/Zip:

Phone: Home: ())

 Work: ())

 Cell: ())

DOB:

SSN:

Diagnosis/ICD-9 Code(s):

1)

2)

3)

Reason for Referral (circle):

Consultation

Specific Treatment Requested: _____

Referring Provider: *(Patients are required to be under the care of a PCP.)*

Referring Provider:

PCP:

Phone:

Phone:

Fax:

Fax:

Insurance Information:

Primary Ins.:

Secondary Ins.:

Policyholder:

Policyholder

Policy ID:

Policy ID #:

Group #:

Group #:

Phone #:

Phone #:

Authorization #:

Authorization #: