Children's HOSPITAL • ST. LOUIS
BJC HealthCare

Washington University in St. Louis

REFERRAL: PEDIATRIC PAIN MANAGEMENT
PHONE (314)454-6246 FAX (314) 454-2296

Thank you for your request for a pain management consultation. To help us address your needs, please complete this information document and return by fax as soon as possible. Please include copies of medical records, labs, tests, etc. We will call the family to set up a visit after reviewing the medical records. (Any medical records in Allscripts/BJC Clindesktop is not necessary to send.)

Referral Date_____ Office Contact_____Phone_____

Patient Name_____ **DOB**_____ **MR**#_____

Address_____

Phone numbers (Home)_____(**Cell)**_____
Parents_____

Referring Physician_____**Phone** #_____**Fax #**_____
Primary Physician_____**Phone** #_____Fax #_____

Pain Problem:

_____

_____

PMH:_____

_____

Medications: _____

Stressors/School Attendance_____
PT/OT attended_____

Labs and/or Imaging (Please include copies)_____

Diagnostic or therapeutic Blocks_____

Psychiatry/Psychology Involvement_____

Please fill out below completely even if in Allscripts/BJC Clindesktop

Insurance:_____**Policy number**_____**Telephone Number:**_____

Insured Employer_____ **Insured's Place of Employment**_____**Insured's DOB**_____

Office Staff Only: Clinic Visit set up for _____*Paperwork mailed*_____

*Precertification obtained*_____