UNIVERSITY OF MARYLAND PAIN MANAGEMENT CENTER
PROVIDER REFERRAL/REQUEST FORM

KERNAN HOSPITAL 2200 KERNAN DR. BALTIMORE, MD 21207

Patient Phone Line: 410 448-6824

DATE: ***Physician Phone Line: 410-448-6622***

Referring Provider Name: _____ **Phone:** **Fax:**

Address: **Email:**

How did you hear about us? Circle one:

Physician Meeting/Lecture Brochure Magazine /Journal Newspaper TV Website Radio Other

Please Complete this Form and Fax to 410-448-7150

Patient Information:

☐ **PLEASE INDICATE IF THIS IS A CANCER PATIENT**

Patient Name:

Patient Insurance:

Date of Birth:

Patient MRN #:
(Kernan, UMMS or UPI # if applicable)

Home/Cell Phone #:

Work Phone #:

☐ Referral for Pain Management Consultation:

Diagnosis:

Pertinent History:

List Current Medications :

Referral for Procedure (check below):

☐ Epidural Steroid Injection:
Circle one: Lumbar Cervical Thoracic

☐ Lumbar Selective Nerve Root Block
Level(s):

☐ Cervical Selective Nerve Root Block -diagnostic only
Level(s):

☐ Facet Block:
Circle one: Lumbar Cervical Thoracic

☐ Radiofrequency Lesioning:
Circle one: Cervical Lumbar Thoracic SI Joint

☐ Epidural Blood Patch

☐ Kyphoplasty
Circle one: Lumbar Cervical Thoracic

☐ Discogram:
Circle one: Cervical Lumbar
Level(s):

☐ Sacroiliac Joint Injection:
Circle one: Right Left Bilateral

☐ Other Somatic/Sympathetic Nerve Block(s)
Please Specify:

☐ Spinal Cord Stimulator

☐ Peripheral Nerve Stimulator

☐ Intrathecal Pump
Circle one: Cancer Spasticity Chronic Pain

FOR ALL REQUESTS, PLEASE ATTACH THE FOLLOWING INFORMATION:

- MOST RECENT NOTES DESCRIBING THE PATIENT'S PAIN PROBLEM AND TREATMENTS
- DIAGNOSTIC TEST REPORTS I.E. X-RAYS/MRI/CT/LAB TESTS PERTINENT TO PAIN PROBLEM (IF AVAILABLE)

UPON RECEIPT, THE PATIENT WILL BE CONTACTED WITH AN APPOINTMENT DATE.