

FAX- Referral Form

Date: _____	Number of pages including cover sheet _____
To: Montana Spine & Pain Center-Scheduling	Fax 406-329-5697

From: _____
Name of Referring Provider: _____
Phone: _____ Fax: _____

Patient Name: _____	Date of Birth: _____
Patient Phone: _____	

<p><u>Persistent Pain Evaluations</u></p> <p> <input type="checkbox"/> New Patient- Persistent Pain * <input type="checkbox"/> Pain School <input type="checkbox"/> Other: _____ </p> <p>*Persistent pain new patient process: Patients attend free orientation and may then choose to schedule with our psychologist for a pain focused assessment and treatment recommendations – including interdisciplinary consultation as indicated.</p>	<p><u>Spine Evaluations</u></p> <p> <input type="checkbox"/> New Patient- Spine Evaluation <input type="checkbox"/> Injection: Left Right Bilateral Location: _____ Type: _____ </p> <p> <input type="checkbox"/> EMG/NCS: Left Right Bilateral Upper Extremity Lower Extremity </p> <p> <input type="checkbox"/> Other: _____ </p>
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Please note, accepting a patient referral does not imply that we will assume responsibility for prescribing of any medication. All recommendations and decisions in this regard are made on a case by case basis after thorough evaluation.

The preponderance of current medical evidence suggests that chronic opioid therapy for noncancer pain is more harmful than beneficial in most patients in the long term.

CONFIDENTIALITY NOTICE

Protected Health Information is personal and sensitive information related to a person’s health care. It is being faxed to you after appropriate authorization from the individual or under circumstances that don’t require individual authorization. You, the recipient, are obligated to maintain it in a safe, secure and confidential manner. Re-disclosure without additional individual consent is prohibited, except as permitted by law. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in Federal and State law.

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