US Pain and Rehabilitation Center

Date:_____

Patient Information:

Patient Name: _____ Sex: ☐ **M** ☐ **F** Date of Birth:_____

Address: _____ City:_____ State:_____ Zip:_____

Phone #: _____ Transportation: ☐ **Yes** ☐ **No** Translator: ☐ **Yes** ☐ **No** Language _____

Reason for Referral:

☐ Pain Evaluation and Treatment

☐ Interventional Procedures (ex. Epidurals, Facet Joint Nerve Blocks)

For Work Comp ONLY: (Circle Answers)

1) Would you like USPRC Providers to become PRIMARY on this case ☐ **Yes** ☐ **No**

2) Has the patient been given work restrictions ☐ **Yes** ☐ **No** (If Yes please send a copy of the restrictions with this form.)

Patient's Signs & Symptoms _____

_____

_____

_____

Insurance & Attorney Information:

Circle one: Auto Accident / Workers Compensation

Insurance:_____ Claim#:_____ Date of Accident:_____

Attorney Name: _____ Attorney Phone #_____

Referring Physician Information:

Physician Name (print)_____ Phone#:_____

Physician Signature:_____ Fax#:_____

Clinic Name:

Email:

1997 Sloan Place, Suite 23, Saint Paul, MN 55117
P: 651-800-4909 F: 651-800-4906

***Please provide any diagnostic reports or imaging along with referral form.**

Email: info@uspainandrehabcenter.com