OREGON PAIN ADVISORS

Referral Form

Pain Resiliency Program
140 S. Holly St.
Medford, OR 97501
Phone: (541) 774-3855
Fax: (541) 787-4711

Patient Information

Name: _____
Date of Birth: _____
Street Address: _____
City & Zip Code: _____
Phone: _____
Insurance Coverage: _____

Referring Provider Information

Name: _____
Address: _____
City & Zip Code: _____
Phone: _____
Fax: _____

NOTE – Please include list of past and current medications.

NOTE – It is preferable that patient has had annual physical within the last 3-6 months and if applicable please include encounter notes and any other testing and/or imaging in relation to diagnoses of pain condition.

Diagnosis code(s): _____

Treatment(s) to date:

☐ Specialist: _____
☐ Physical Therapy: _____
☐ Chiropractic: _____
☐ Other: _____

Symptom(s): _____

_____

Known history of substance abuse and/or positive screening results:

☐ Yes ☐ No

_____ _____
Signature of Person Making Referral **Date**

PAIN RESILIENCY PROGRAM USE ONLY:

Patient scheduled for initial program orientation on: _____