



The University of Texas at Austin
UT Health Austin

Thank you for considering The UT Health Austin Comprehensive Pain Management team for the care of your patient.

We focus on delivering safe and effective care that will make a positive difference in the quality of life and functional status for adult patients with varied, complex and challenging pain conditions.

If you would like to speak with someone about our scope of services or a specific patient before sending us a referral, we would be happy to speak with you.

Health Transformation Building
1601 Trinity Street Austin, Texas 78712
Phone: 1-833-UT-CARES (833-882-2737)
Fax: 512-495-5457
uthealthaustin.org

Comprehensive Pain Management Referral Form

*** Indicates the only required information.**

We would appreciate you also providing the other information listed below, **if readily available**, with this referral form — of which our Comprehensive Pain Management team will use in its initial comprehensive evaluation of your patient.

PATIENT INFORMATION

*** Last Name:** _____ *** First Name:** _____ *** Sex:** Male Female

*** DOB (mm/dd/yyyy):** ____/____/____ *Please note: We only accept referrals for patients 18 years and older.*

*** Please include a patient-signed Authorization to Release Health Information to UT Health Austin.**

Address: _____ Zip: _____

E-Mail Address: _____

Mobile Phone: _____ Home Phone: _____ Alternative Phone: _____

Insurance Company: _____ Policy Number: _____

REFERRAL INFORMATION

*** Referring Physician's Name:** _____

*** Are you the patient's Primary Care Provider (PCP)?** Yes No

*** If not you, Primary Care Physician's Name:** _____

*** Reason for Referral:** _____

*** Type of Referral:** Consult Co-Management Consideration for Transfer of Care

Comments on pain history or other pertinent information (optional):

OTHER PROVIDER INFORMATION

If applicable, Psychiatrist Name: _____

Previous Pain Management Specialist's Name: _____

Other Specialists (for Comorbidities): _____

CLINICAL DOCUMENTS / INFORMATION

If readily available (but optional), please attach:

- Referring Physician's most recent note (if you are not the patient's Primary Care Physician)
- Primary Care Physician's 3 most recent visit notes
- If applicable, Psychiatrist's 3 most recent visit notes
- All notes from any previous pain management clinics
- Results of recent chronic pain-related radiologic imaging (CT, MRI) and other diagnostic tests (EMG/NCS)
- All current medications with dosages
- List of current medical problems and comorbidities