The University of Texas at Austin
UT Health Austin

We appreciate you 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 (HTB)
1601 Trinity Street, Bldg. A
Austin, Texas 78712
Phone: 1-833-UT-CARES (833-882-2737)
Fax: 512-495-5457
uthealthaustin.org

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Comprehensive Pain Management Referral Form

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*

.

Address: _____ Zip: _____

E-Mail Address: _____

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

Insurance Company: _____ Policy Number: _____

REFERRAL INFORMATION

Referring Physician's Name: _____

Referring Physician's Location: _____

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 (Please check one): ___Consult ___Co-Management ___Consideration for Transfer of Care

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

_____

_____

_____

_____

CLINICAL INFORMATION: Please provide a copy of your most recent office/clinic note, and any other readily available, pertinent clinical information, including laboratory tests and radiology imaging reports.

Thank you again.