Chronic Pain Referral Form

Kaweah Health
MORE THAN MEDICINE. LIFE.

202 W. Willow Ave., Suite 202 • Visalia, CA 93291 • Phone: (559) 624-6965 • Fax: (559) 625-7594

Referring MD Name: _____

Telephone: _____ Fax: _____

Address: _____

_____

Primary Care Physician (if different from above): _____

Patient Name: _____ Date of Birth: _____

Medical Record Number (if applicable): _____ Insurance: _____

Pain Diagnosis/Indications*: _____

_____

Current Medications: _____

_____

_____

Failed Therapies: _____

_____

_____

In referring my patient, I acknowledge that I will resume care of my patient after discharge/graduation from Kaweah Health Medical Clinic-Willow.

***Attach any and all documentation supporting pain diagnosis**

Signature: _____ Date: _____