Decatur County Memorial Hospital
The Quality Care You Want. Close By.

**Pain Management Center**
**720 N. Lincoln Street, Greensburg IN 47240**
**Phone: 812-663-1185 • Fax: 812-663-1184**

# Referral Form

## Dr. Danielle Turnak

**Please fax this completed form to 812-663-1184 with the following information. We will call the patient directly.**

- **Copy of patient's insurance card**
- **Physician Notes**
- **Testing, including MRIs, x-rays, and EMGs**

Referring Physician: _____ Physician Phone: _____ Date: _____
(Print first & last name)

Patient Name: _____ DOB: _____

Social Security No. _____-_____-_____ Diagnosis_____

Home Phone: _____ Cell Phone: _____

Address: _____

**Reason for Referral:** ☐ **Evaluation and Treatment**
☐ **Evaluation and Procedure Only:** _____
(Input requested procedure)

**Has the patient:** ☐ **Exhibited drug seeking behaviors**
☐ **Been non-compliant with opioid therapy in the past**
☐ **Demonstrated accelerated medication use or misplaced opioid medications or prescriptions**

**Medication History:**

| | | |
|---|---|---|
| ☐ **Butrans Patch** | ☐ **Morphine,Embedda,Kadian,Avinza** | ☐ **Percocet/Percodan** |
| ☐ **Dilaudid** | ☐ **Tramadol/Ultram** | ☐ **Tylenol #3** |
| ☐ **Exalgo** | ☐ **Nucynta** | ☐ **Vicodin/Vicoprofen** |
| ☐ **Fentanyl/Duragesic** | ☐ **Opana/Oxymorphone** | |
| ☐ **Methadone** | ☐ **Oxycodone/Oxycontin** | |

**Previous Pain Management:** ☐ Yes ☐ No Diagnosis: _____
**If Yes, please provide additional information:** Physician / Location: _____ Year:_____

**Worker's Compensation**
Claim # _____ Date of Injury: _____
Physician of Record _____ Allowed Diagnosis: _____
Employer through which claim was filed: _____

**Motor Vehicle Accident:** ☐ Yes ☐ No **Litigation:** ☐ Yes ☐ No

**Insurance:** *Complete insurance information if copy of insurance card not attached.*

Primary Insurance: _____ Subscriber: _____

Subscriber ID: _____

Secondary Insurance: _____ Subscriber: _____Subscriber ID:_____