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:_____