University Center for Pain Management
UCPM of knoxville
reclaim relief & function

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REFERRAL FORM

Requested Physician ☐ First Available ☐ Jason M. Buehler MD ☐ Mark B. Murray MD
☐ Jeffrey B. Staack MD ☐ Mathew B. Vance MD ☐ Stephanie G. Vanterpool MD, MBA

Please Fax this completed form, along with ☐ Office Notes, ☐ Imaging, ☐ Insurance Card

Referring Provider | Phone | Fax

PATIENT INFORMATION

Last Name | First Name | MI | DOB

Address | City | State | Zip

Home Phone | Work Phone

INSURANCE INFORMATION (**Attach a copy of Front and Back of Insurance Card**)

Insurance Company Name | Policy # | Group #

Address | City | State | Zip

Phone | Fax | Co-Pay | Deductible

Insurance Authorization # | # Visits Authorized | Claim # | Date of Injury

SERVICES

☐ Consultation only
☐ Referral With Ongoing Management
☐ Consultation with Procedure as Appropriate
☐ Procedures Only (Please check desired choice)

DIAGNOSIS

☐ Headache
☐ Neck Pain
☐ Back Pain
☐ Thoracic
☐ Lumbar
☐ Abdominal Pain
☐ Radiculopathy (Level_____)
☐ Myofascial Pain/Fibromyalgia
☐ Neuropathic Pain
☐ Failed Back Surgery Syndrome
☐ Extremity Pain (_____)
☐ Complex Regional Pain Syndrome
☐ Other (Please Specify)_____

PROCEDURE ONLY (Must be Pre-authorized)

☐ Epidural Steroid Level _____
☐ Transforaminal Epidural Level _____ Side:_____
☐ Facet Joint Injection Level _____ Side:_____
☐ Discogram Area _____
☐ Intra-articular steroid Joint _____ Side:_____
☐ SI Joint Injection Side:_____
☐ Pump Evaluation
☐ Spinal Cord Stimulation
☐ Other (Please Specify) _____

FOLLOW-UP CARE

☐ I would like continue to manage this patient after the procedure
☐ I am referring the patient to you for long-term management.

Our office will contact the patient to schedule an appointment