Form # PAIN-2350-FF
Orig 10/05 Rev 10/11

ACMH HOSPITAL
One Nolte Drive
Kittanning, PA 16201

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Pain Center

Faxed Request for Consult

Pain Center Fax Number: (724) 543-8743

Patient's Name: _____ MR#: _____ Date of Request: _____

Patient's Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Date of Birth: _____ Social Security Number: _____

Insurance: Primary: _____ Secondary: _____

Primary Care Physician: _____ Phone: _____ Fax: _____

Referring Physician / Clinician: _____ Phone: _____ Fax: _____

Symptoms / Reason for Referral: _____

DIAGNOSIS (Please check all that apply) For Pain Management or Intrathecal Baclofen

Spasticity / Spasms Due To:

_____ Brain Injury _____ Cerebral Palsy _____ Multiple Sclerosis

_____ Spinal cord Injury _____ Stroke _____ Not Sure

_____ Other _____

Malignant / Nonmalignant Pain Due To: _____ Acute _____ Chronic

___ Arachnoiditis ___ Cancer ___Complex Regional Pain Syndrome / Reflex Sympathic Dystrophy (RSD)

____Degenerative Disc Disease ____ Disc Herniation ____ Failed Back Surgical Syndrome (FBSS)

____Peripheral Nerve Injury _____Other _____

Please attach a copy of the patient's demographic information and insurance card(s).

Please forward all relevant x-rays, diagnostic studies, and medical records.

***** Please note if the diagnostic study was performed at ACMH, just list the study and we can obtain the report ourselves: _____**