



Dr. Randy Barrett, DO
Dr. Levi Zimmerman, MD
Sandi Hellgren, PA-C
Allison Nichols, PA-C

Pain Management Center
Faxed Request for Consult
Pain Management 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.