Children's Hospital of Wisconsin®

A member of Children's Hospital and Health System.

Chronic Pain Clinic Consultation Referral Form

Phone: 414-266-2775 • Fax: 414-266-1761

Thank you for referring your patient to the Jane B. Pettit Pain Clinic. Please provide the following information and pertinent medical records so that we can provide the best and most timely service.

Patient Information

Patient Name: _____

D.O.B. _____ M/F _____

Parent/Guardian Name(s): _____

Patient Address: _____

_____

Home Phone Number: _____

Cell Phone Number: _____

Work Phone Number: _____

Insurance Carrier: (member number, if known):

_____

Referring Provider Information

Provider Name: _____

Provider Address: _____

_____

Phone Number: _____

Fax Number: _____

Email: _____

Contact person in your practice: _____

_____

Please describe the patient's chief complaint and include onset and frequency:

_____

_____

_____

_____

Other providers/specialties the patient has seen for this condition: _____

_____

Previous treatment and diagnostic test for pain condition and response: _____

_____

_____

Is the patient frequently absent from school? ☐ Yes ☐ No

Is the patient cognitively impaired or nonverbal? ☐ Yes ☐ No

What service are you seeking at this clinic?

☐ Evaluation (diagnosis and treatment recommendations only)

☐ Treatment and follow-up of condition

If you believe your patient only needs **Cognitive Behavior Therapy**, please refer the patient to the **Psychiatry Clinic** (414-266-3339) or a **pediatric psychologist** or **psychotherapist** in the community. If you are seeking **Biofeedback** services, these are available through the **Children's Hospital Occupational Therapy Department** (414-266-2815).

Please sign and fax this form to 414-266-1761. Please initiate delivery of pertinent medical records either by fax or mail. When this form is received, your request will be reviewed and processed.

Referring Provider Signature: _____ **Date:** _____ **Time:** _____ **(Required)**

OFFICE USE ONLY

Date Received: _____ Clinic/Clinician Assigned: _____

☐ Referral Accepted Date and Time of Appointment: _____

☐ Referral Denied Reason: _____

Notes: _____

_____

_____

APPLY DT BARCODE STICKER
MD Referral Accepted DT346
MD Referral Denied DT9901