UCPM
UNIVERSITY CENTER FOR PAIN MANAGEMENT OF KNOXVILLE
Reclaim Relief & Function

"Accurate Diagnosis and Targeted Treatment of Pain"

Email to UCPMKreferrals@utmck.edu
OR fax to (865)305-4025

New Patient Referral Form

Requested UCPM Physician _____ ☐ **First Available**

Referring Provider _____

Physician Name Phone No Fax No

PATIENT INFORMATION (Please submit full patient demographic page with referral)

_____

Last Name First Name: DOB

_____

Home Phone Cell Phone Email Address

REFERRAL TYPE

☐ **Interventional Referral –** Opioid therapy will **NOT** be considered as part of evaluation

☐ **Comprehensive Referral –** Opioid therapy **MAY** be considered as part of evaluation

Do any of the following apply?

Blood Thinners ☐ Yes Pacemaker ☐ Yes Other Implanted Device ☐ Yes

PAIN COMPLAINT (What is the main area/location of pain?)

_____

Has the patient had a previous surgery in the area to be treated? _____

Please include the following ☐ **Radiological study of affected pain within 2 years of referral date.** ☐ **Progress Notes dated within 3 months of referral date.**

INSURANCE INFORMATION (Please submit a front and back copy of insurance cards)

Primary Insurance	**Secondary Insurance**
Insurance _____	Insurance _____
ID # _____	ID # _____