REFERRAL FORM FOR PSYCHOLOGICAL SERVICES

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MANDATORY DOCUMENTS TO SEND TO COMPLETE REFERRAL PROCESS:

- ☐ This completed form along with:
- ☐ Pt. demographics & insurance (face sheet)
- ☐ **Copy of insurance card (mandatory)**
- ☐ Most recent doctor's chart note
- ☐ Our New Patient Questionnaire (8 pages)

I am referring the following patient:

Name: _____DOB:_____

Phone Number: (_____) _____

for psychological service as checked below:

CHECK BELOW: **Psychological Clearance for :**

IMPLANTABLES

- ☐ **Spinal Cord Stimulator (SCS)**
- ☐ **Intrathecal Pain Pump**
- ☐ **Dorsal Root Ganglion Stimulator (DRG)**
- ☐ **Peripheral Nerve Stimulator (PNS)**

- ☐ **INTERVERTEBRAL RADIOFREQUENCY ABLATION BASIVERTEBRAL NERVE**

_____

Referring Physician: _____ **NPI:**_____

Address: _____ **Phone:** _____

_____ **Fax:** _____

_____

CONTACT PERSON: _____
(please provide OFFICE STAFF CONTACT PERSON)

EMAIL: _____
(Fax is where reports go to die. Please provide contact email for most effective communication)

UPDATED 04-30-2025

TIMOTHY L. SAMS, PH.D.
PACE, INC

Phone 208-255-4846 714-404-0183; Fax 714-526-1602
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PATIENT INFORMATION AND FEE AGREEMENT

***** YOU MUST FILL OUT ALL OF THE REQUESTED INFORMATION & SIGN*****

Patient Name: _____ DOB:_____ Age: ____ Sex: (M) (F)
(Last, First, Middle Initial)

Address: _____
Number Street City State Zip

Preferred phone: ( )_____Email Address: _____

Referred by Dr.:_____Phone: ( ) _____

YOU MUST COMPLETE THE REQUESTED INFORMATION LEGIBLY AND IN FULL INCLUDING YOUR NAME AS IT APPEARS ON YOUR MEDICARE CARD. WE WILL BILL YOUR MENTAL HEALTH INSURANCE BASED SOLELY ON THE INFORMATION YOU LIST BELOW. WE WILL NOT USE INFORMATION FROM THE REFERRING OFFICE OR AN ATTACHED INSURANCE CARD. WE ACCEPT MEDICARE, BUT NO OTHER INSURANCE. CASH PATIENTS WILL PAY $195 AS PAYMENT IN FULL AT THE TIME OF YOUR APPOINTMENT BY CREDIT OR DEBIT CARD. REGULAR MEDICARE COVERS MENTAL HEALTH SERVICES, BUT ANY MEDICARE REPLACEMENT PLAN LIKE UHC, SCAN, HUMANA, OR IEHP, ETC., WILL NOT COVER OUR SERVICES.

EVERYONE NEEDS TO COMPLETE INSURANCE INFORMATION IN FULL

MEDICARE NAME: _____

Insured Member Name from your Medicare Card:_____DOB: _____

NAME OF SECONDARY HEALTH INSURANCE: _____

Insured Member Name from your insurance card:_____DOB: _____

Insured Member ID#:_____Policy/Group#_____

The above information is true to the best of my knowledge. I authorize my Medicare insurance benefits to be paid directly to PACE, Inc unless I pay by debit or credit card in full at the time of the appointment. I fully understand that I am the responsible party for all charges incurred by me at this practice. **I am solely responsible for verifying my insurance coverage and I know that neither Dr. Sams' office nor the referring doctor has verified my insurance coverage. The initial consultation and assessment fees include the following services: clinical interview, review of available records, several hours of psychological testing, mental status evaluation, determination of clearance, patient education, and report writing, which is paid at the highest level of medical complexity. I** authorize PACE, Inc to release 1) all information necessary to secure payment; and 2) any relevant information to the referring physician. If my interview is through telemedicine, I consent to the use of that modality and understand that that are greater risks to confidentiality. For telecommunication assessments, Dr. Sams will be alone during the interview and I will have no more than one support person in the room with me. My interview will not be recorded or stored electronically. By signing this form, I acknowledge all of the above.

Patient Signature: _____ *Date:* _____

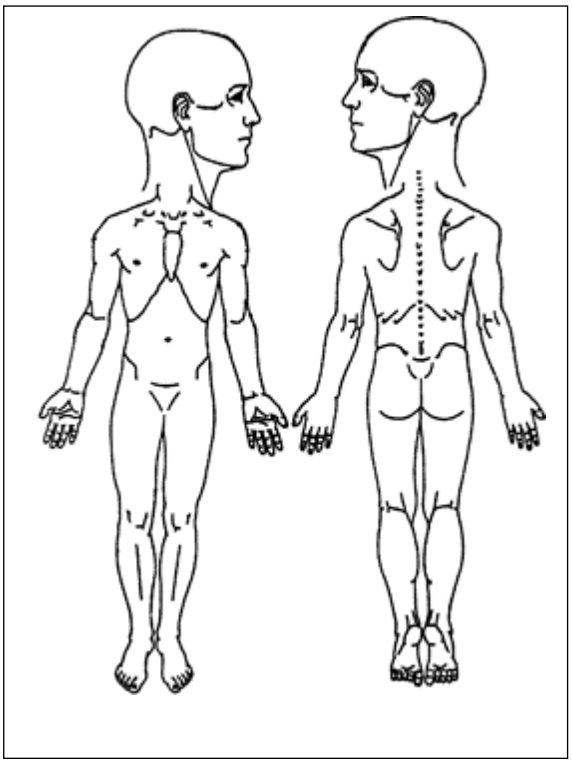
SHORT FORM McGILL PAIN QUESTIONNAIRE and PAIN DIAGRAM

Date:_____

Name: _____

Check the column to indicate the level of your pain for each word, or leave blank if it does not apply to you.

		Mild	Moderate	Severe
1	Throbbing			
2	Shooting			
3	Stabbing			
4	Sharp			
5	Cramping			
6	Gnawing			
7	Hot-Burning			
8	Aching			
9	Heavy			
10	Tender			
11	Splitting			
12	Tiring-Exhausting			
13	Sickening			
14	Fearful			
15	Cruel Punishing			



Mark or comment on the above figure where you have your pain.

Indicate on the line in the box below how bad your pain is

NO PAIN **WORST POSSIBLE PAIN**

S	/33	A	12	VAS	/10

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Oswestry Disability Index

Name:_____ Date:_____

Section 1 – Pain Intensity

- □ I have no pain at the moment.
- □ The pain is very mild at the moment.
- □ The pain is moderate at the moment.
- □ The pain is fairly severe at the moment.
- □ The pain is very severe at the moment.
- □ The pain is the worst imaginable at the moment

Section 2 – Personal Care (washing, dressing, etc.)

- □ I can look after myself normally but it is very painful.
- □ It is painful to look after myself and I am slow and careful.
- □ I need some help but manage most of my personal care.
- □ I need help every day in most aspects of my personal care.
- □ I need help every day in most aspects of self-care.
- □ I do not get dressed, wash with difficulty, and stay in bed.

Section 3 - Lifting

- □ I can lift heavy weights without extra pain.
- □ I can lift heavy weights but it gives extra pain.
- □ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (i.e. on a table).
- □ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- □ I can lift only very light weights.
- □ I cannot lift or carry anything at all.

Section 4 – Walking

- □ Pain does not prevent me walking any distance.
- □ Pain prevents me walking more than 1 mile.
- □ Pain prevents me walking more than ¼ of a mile.
- □ Pain prevents me walking more than 100 yards.
- □ I can only walk using a stick or crutches.
- □ I am in bed most of the time and have to crawl to the toilet.

Section 5 – Sitting

- □ I can sit in any chair as long as I like.
- □ I can sit in my favorite chair as long as I like.
- □ Pain prevents me from sitting for more than 1 hour.
- □ Pain prevents me from sitting for more than ½ hour.
- □ Pain prevents me from sitting for more than 10 minutes.
- □ Pain prevents me from sitting at all.

Section 6 – Standing

- □ I can stand as long as I want without extra pain.
- □ I can stand as long as I want but it gives me extra pain.
- □ Pain prevents me from standing more than 1 hour.
- □ Pain prevents me from standing for more than ½ an hour.
- □ Pain prevents me from standing for more than 10 minutes.
- □ Pain prevents me from standing at all.

Section 7 – Sleeping

- □ My sleep is never disturbed by pain.
- □ My sleep is occasionally disturbed by pain.
- □ Because of pain, I have less than 6 hours sleep.
- □ Because of pain, I have less than 4 hours sleep.
- □ Because of pain, I have less than 2 hours sleep.
- □ Pain prevents me from sleeping at all.

Section 8 – Sex life (if applicable)

- □ My sex life is normal and causes no extra pain.
- □ My sex life is normal but causes some extra pain.
- □ My sex life is nearly normal but is very painful.
- □ My sex life is severely restricted by pain.
- □ My sex life is nearly absent because of pain.
- □ Pain prevents any sex life at all.

Section 9 – Social Life

- □ My social life is normal and cause me no extra pain.
- □ My social life is normal but increases the degree of pain.
- □ Pain has no significant effect on my social life apart from limiting my more energetic interests, i.e. sports.
- □ Pain has restricted my social life and I do not go out as often.
- □ Pain has restricted social life to my home.
- □ I have no social life because of pain.

Section 10 – Traveling

- □ I can travel anywhere without pain.
- □ I can travel anywhere but it gives extra pain.
- □ Pain is bad but I manage journeys of over two hours.
- □ Pain restricts me to short necessary journeys under 30 minutes.
- □ Pain prevents me from traveling except to receive treatment.

Section 11 - Previous Treatment

- □ Over the past three months have you received treatment, tablets or medicines of any kind for your back or leg pain? Please check the appropriate box.
- □ No
- □ Yes (if yes, please state the type of treatment you have received)

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Zung Self-rating Anxiety Scale

Name:_____ **Date:**_____

Listed below are 20 statements. Please read each one carefully and decide how much the statement describes

How you have been feeling during the past week. Circle the appropriate number for each statement.	None or a little of the time	Some of the time	Good part of the time	Most or all of the time
1. I feel more nervous and anxious than usual.	1	2	3	4
2. I feel afraid for no reason at all.	1	2	3	4
3. I get upset easily or feel panicky.	1	2	3	4
4. I feel like I'm falling apart and going to pieces.	1	2	3	4
5. I feel that everything is all right and nothing bad will happen.	4	3	2	1
6. My arms and legs shake and tremble.	1	2	3	4
7. I am bothered by headaches, neck and back pains.	1	2	3	4
8. I feel weak and get tired easily.	1	2	3	4
9. I feel calm and can sit still easily.	4	3	2	1
10. I can feel my heart beating fast.	1	2	3	4
11. I am bothered by dizzy spells.	1	2	3	4
12. I have fainting spells or feel faint.	1	2	3	4
13. I can breathe in and out easily.	4	3	2	1
14. I get feelings of numbness and tingling in my fingers and toes.	1	2	3	4
15. I am bothered by stomachaches or indigestion.	1	2	3	4
16. I have to empty my bladder often.	1	2	3	4
17. My hands are usually dry and warm.	4	3	2	1
18. My face gets hot and blushes.	1	2	3	4
19. I fall asleep easily and get a good night's rest.	4	3	2	1
20. I have nightmares.	1	2	3	4

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Date:_____ **Name:** _____

Zung Self-Rating Depression Scale (SDS)

For each item below, please place a check mark (✓) in the column which best describes how often you felt or behaved this way during the past several days

Place check mark (✓) in correct column.	A little of the time	Some of the time	Good part of the time	Most of the time
1. I feel down-hearted and blue.				
2. Morning is when I feel the best.				
3. I have crying spells or feel like it.				
4. I have trouble sleeping at night.				
5. I eat as much as I used to.				
6. I still enjoy sex.				
7. I notice that I am losing weight.				
8. I have trouble with constipation.				
9. My heart beats faster than usual.				
10. I get tired for no reason.				
11. My mind is as clear as it used to be.				
12. I find it easy to do the things I used to.				
13. I am restless and can't keep still.				
14. I feel hopeful about the future.				
15. I am more irritable than usual.				
16. I find it easy to make decisions.				
17. I feel that I am useful and needed.				
18. My life is pretty full.				
19. I feel that others would be better off if I were dead.				
20. I still enjoy the things I used to do.				

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FATIGUE SEVERITY SCALE (FSS)

Date_____ **Name** _____

Please circle the number between 1 and 7 which you feel best fits the following statements. This refers to your usual way of life within the last week. 1 indicates “strongly disagree” and 7 indicates “strongly agree.”

Read and circle a number.	Strongly Disagree →						Strongly Agree
1. My motivation is lower when I am fatigued.	1	2	3	4	5	6	7
2. Exercise brings on my fatigue.	1	2	3	4	5	6	7
3. I am easily fatigued.	1	2	3	4	5	6	7
4. Fatigue interferes with my physical functioning.	1	2	3	4	5	6	7
5. Fatigue causes frequent problems for me.	1	2	3	4	5	6	7
6. My fatigue prevents sustained physical functioning.	1	2	3	4	5	6	7
7. Fatigue interferes with carrying out certain duties and responsibilities.	1	2	3	4	5	6	7
8. Fatigue is among my most disabling symptoms.	1	2	3	4	5	6	7
9. Fatigue interferes with my work, family, or social life.	1	2	3	4	5	6	7

VISUAL ANALOGUE FATIGUE SCALE (VAFS)

Please mark an “X” on the number line which describes your global fatigue with 0 being worst and 10 being normal.

0	1	2	3	4	5	6	7	8	9	10

NAME:_____ **DATE:**_____

Current Opioid Misuse Measure (COMM)®

Please answer each question as honestly as possible. Keep in mind that we are only asking about the past 30 days. There are no right or wrong answers. If you are unsure about how to answer the question, please give the best answer you can.

Please answer the questions using the following scale:	Never 0	Seldo 1	Sometim 2	Often 3	Very 4
1. In the past 30 days, how often have you had trouble with thinking clearly or had memory problems?	0	0	0	0	0
2. In the past 30 days, how often do people complain that you are not completing necessary tasks? (i.e., doing things that need to be done, such as going to class, work or appointments)	0	0	0	0	0
3. In the past 30 days, how often have you had to go to someone other than your prescribing physician to get sufficient pain relief from medications? (i.e., another doctor, the Emergency Room, friends, street sources)	0	0	0	0	0
4. In the past 30 days, how often have you taken your medications differently from how they are prescribed?	0	0	0	0	0
5. In the past 30 days, how often have you seriously thought about hurting yourself?	0	0	0	0	0
6. In the past 30 days, how much of your time was spent thinking about opioid medications (having enough, taking them, dosing schedule, etc.)?	0	0	0	0	0
7. In the past 30 days, how often have you been in an argument?	0	0	0	0	0
8. In the past 30 days, how often have you needed to take pain medications belonging to someone else?	0	0	0	0	0
9. In the past 30 days, how often have you been worried about how you're handling your medications?	0	0	0	0	0
10. In the past 30 days, how often have you had to make an emergency phone call or show up at the clinic without an appointment?	0	0	0	0	0
11. In the past 30 days, how often have you gotten angry with people?	0	0	0	0	0
12. In the past 30 days, how often have you had to take more of your medication than prescribed?	0	0	0	0	0
13. In the past 30 days, how often have you borrowed pain medication from someone else?	0	0	0	0	0
14. In the past 30 days, how often have you used your pain medicine for symptoms other than for pain (e.g., to help you sleep, improve your mood, or relieve stress)?	0	0	0	0	0
15. In the past 30 days, how often have you had to visit the Emergency Room?	0	0	0	0	0

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MEDICATIONS

PLEASE LIST YOUR MEDICATIONS BELOW

Name:_____ **Date:**_____

Medication Name	Strength	Average # of pills each day	Why you take it