Thank you for your referral!

SPECIALTY PAIN CARE

Please e-mail or fax form:
Email: referrals@specialtypaincare.com
Fax: (877) 409-3960 / (626) 609-4195

Pain Management Referral Form

Reason for Referral: _____ **Date of Referral:** 01/21/2026

Location of patient's pain:

☐ Mid back ☐ Low back ☐ Neck

☐ Head ☐ Shoulder (☐ Left/☐ Right/☐ Both) ☐ Elbow (☐ Left/☐ Right/☐ Both)

☐ Wrist (☐ Left/☐ Right/☐ Both) ☐ Hand (☐ Left/☐ Right/☐ Both) ☐ Hip (☐ Left/☐ Right/☐ Both)

☐ Knee (☐ Left/☐ Right/☐ Both) ☐ Ankle (☐ Left/☐ Right/☐ Both) ☐ Foot (☐ Left/☐ Right/☐ Both)

☐ OTHER _____

Insurance Information:

Insurance name _____ Subscriber's name _____

Insurance ID # / Claim # _____

Patient Information:

Name _____ DOB _____

Gender _____

Primary address _____

City _____ State _____ Zip _____

Home phone _____ Work phone _____ Cell phone _____

E-mail _____

Referring Provider Information:

Name _____ Specialty _____

Fax # / E-mail for Report _____ Phone _____

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