Dartmouth Health

Dartmouth Hitchcock Medical Center

Phone: (603) 650-2225
Fax: (603) 676-4080
Medically Urgent Fax: (603) 640-1909

Patient Information:
Patient Name:_____ DOB:_____
Address: _____ City:_____ State:_____ Zip:_____
Home Phone:_____ Cell: _____ Work:_____
Gender: ☐Male ☐ Female ☐ Non-Binary ☐ Declines to list

Please fill this form out completely and as legibly as possible as to not delay the referral process

Diagnosis and Clinical Question: *(Please include demographics, insurance, pertinent office and operative/procedure notes (please limit to 30 pages) and any pertinent imaging and imaging reports with the referral)*
Diagnosis: _____

Clinical Question You Want Answered:
_____
_____

Please note, we do not take over opioid management or prescribe opioids at our facility. We will make recommendations for opioid prescribing or tapering to a referring provider.

_____
Pertinent Image Studies: ☐ MRI ☐ CAT Scan ☐ XRAY ☐ Other (please specify): _____
Images Studies (images and reports) included in referral? ☐ Yes ☐ No
If No, please specify where and when studies were completed:
_____
Are you requesting a specific provider? ☐ Yes ☐ No
If yes, please specify: _____

We offer a number of different services. Please choose from one of the following options:

☐ Pain Specialist Evaluation for a Non-Spine Issue: Evaluation by a pain management specialist to include medication management or injections.

☐ Pain Specialist Evaluation for a Spine Specific Diagnosis: Evaluation by a pain management specialist to include medication management (non-opiate options), injections, Spinal Cord Stimulators, Medication pumps etc. Patient must have had an MRI within the last 12 months or a CT scan is MRI is medically contraindicated.

☐ Surgical Opinion: For patients who have failed conservative treatment and are seeking a surgical opinion for a spine complaint. Patient must have had an MRI within the last 12 months or a CT scan if MRI is medically contraindicated.

☐ Screening Clinic for Spine Specific Diagnosis: for patient without prior work-up or advanced imaging. This is a remote video or phone visit to get a patient clinically triaged by a spine provider and start a plan of care.

☐ Functional Restoration Program: Comprehensive Evaluation for patients with chronic pain lasting for more than 3 months, to assess physical capabilities, personal goals, and make recommendations for rehabilitation.

Existing Implanted Devices:
Does patient have an existing Spinal Cord Stimulator, Intrathecal Pain Pump implanted or any other implanted device? ☐ Yes ☐ No

Referring Provider's Signature:

_____Date:_____