## Specialty Service Referral

# Interventional Pain

**SBL Center for Interventional Pain**
Sarah Bush Lincoln Health Center
1000 Health Center Dr., Suite 106 • Mattoon, IL 61938
217-258-4495 • Fax 217-238-3741

**SBL Interventional Pain Management**
SBL Medical Park Plaza • 901 Medical Park Dr., Suite 201
Effingham, IL 62401
217-347-2332 • Fax 217-347-2313

**SBL Fayette County Hospital -**
Physician Specialty Clinic • 650 West Taylor St.
Vandalia, IL 62471
618-283-5531 • Fax 618-283-4933

Sarah Bush Lincoln

**REFERRING PROVIDER**

Name _____ Phone _____ Fax _____

Reason for Referral _____ Date _____

**PATIENT INFORMATION**

Name _____ Date of Birth _____ Social Security Last 4# _____

Address _____ City _____ State/Zip _____

Phone _____ County _____

Insurance Carrier Primary _____ Secondary _____

If HMO/POS or United Healthcare insurance plan, referral authorization to be obtained by referring office. Authorization # _____

Work Related ❑ Yes ❑ No If yes, Employer _____ Contact _____

Work Comp Carrier _____ Contact _____

**INFORMATION NEEDED**
Please include all the information below.

- ❑ Provider Notes
- ❑ Procedure Reports
- ❑ Appropriate Laboratory Reports
- ❑ Appropriate Imaging Reports
- ❑ Medication and Allergy Lists

**Imaging Information**
Please check the following that apply:

- ❑ EMG
  Date _____ Where _____
- ❑ MRI
  Date _____ Where _____
- ❑ CT Scan
  Date _____ Where _____
- ❑ Xray
  Date _____ Where _____

**Previous Treatment**
Please check the following that apply:

- ❑ Previously seen by a pain specialist
  Date _____ Provider _____
- ❑ Injections/Procedures
  Type _____ Date _____ Where _____
- ❑ Physical Therapy completed in the last 12 months
  Date _____ Length of therapy _____ Where _____

**REFERRING RESPONSE**

- ❑ Patient Scheduled
  Provider _____ Date _____ Time _____
  Comment _____
- ❑ Patient NOT Scheduled
  Additional Information Required _____
  Other Reason _____