Johns Hopkins Pain Treatment Center
601 North Caroline Street, Suite 3062, Baltimore, MD 21287
410/955-7246 * FAX 410/502-2390**

Consult Request Questionnaire

Patient Name:___________________________________ Birthdate:_______________

Address:____

Patient Phone Number:___________________ (work) __________________(home)

Patient Insurance: ____

Referring Physician Completing this form: ___________________________________

NPI # of Referring Physician:____

Phone Number for Referring Physician: _____________________________________

Fax Number for Referring Physician: _______________________________________

Pain Location (be specific):____

Current Pain Meds:____

Previous Pain Meds: ____

Previous Injections: ____

<u>Implantable therapy:</u>

Spinal Cord Stimulator: (circle one) Current Past Neither

Intrathecal Pump: (circle one) Current Past Neither

IT Pump Medication: ____

H/O Addiction or Substance Abuse: Yes No (circle one)

- If yes, please describe and list treatment center:_____________________
  ____

Type of consultation request: (circle one)

- Specific need or question to be addressed:
  ____

This form will be reviewed by our physicians and the patient will be called for an appointment. If for some reason we do not feel we can treat the patient, you will be informed. Thank you.