Pediatric Pain Clinic
Patient Referral Form

Department of Pediatric Anesthesiology, ACH
Pain Medicine Division
1 Children's Way, Slot 203
Little Rock, AR 72202
(501) 364-3100 phone
(501) 364-2939 fax

Please send the following information to ACH

- ✓ This completed form and fax to **501-364-2939**
- ✓ Please send your last clinic note and only the others ones you see necessary. *(full medical record not necessary)*
- ✓ Recent labs
- ✓ Specialist notes: Please send only the original consult and last follow up note for each specialist.
- ✓ Relevant imaging/study reports AND discs.
- ✓ Copy of last physical/occupation therapy report
- ✓ Copy of relevant surgeries, injections, procedures or interventions
- ✓ Copy of insurance card

Patient Information

Patient Name: _____ Patient DOB: _____

Background

Where does your patient hurt?

How long has your patient had this pain?

Are there any relevant images/studies? What did they find?

In your opinion, please describe what has been going on with the patient?

What medications have you prescribed, what dose and how long did the patient take it?

Have they tried physical or occupational therapy? Was this helpful?

Have they had any surgeries, injections, procedures or interventions? Was this helpful?

Are they missing school or normal activities? How often?

Are they having frequent ER visits? How often?

Are there any family dynamics we need to be aware of?

Have you made other referrals to other consultants for this pain? What was their opinion?