

**REFERRAL TO ALLAYANT PAIN MANAGEMENT**

REFERRING PHYSICIAN\_\_\_\_\_

OFFICE PHONE\_\_\_\_\_ OFFICE FAX\_\_\_\_\_

PATIENT NAME\_\_\_\_\_

DOB \_\_\_/\_\_\_/\_\_\_ SS#\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_

HOME PHONE\_\_\_\_\_ CEL PHONE\_\_\_\_\_

ADDRESS\_\_\_\_\_

INSURANCE\_\_\_\_\_

**PATIENT REFERRED FOR:**

\_\_\_\_MANAGEMENT OF CHRONIC PAIN

DIAGNOSIS\_\_\_\_\_

\_\_\_\_HORIZONTAL THERAPY

\_\_\_\_COLD LASER THERAPY

\_\_\_\_SUBOXONE TREATMENT FOR OPIOID ADDICTION

**PLEASE FAX FACE SHEET, RECENT TREATMENT NOTE, AND ANY  
RECENT RADIOLOGY OR SURGERY REPORTS TO 866.922.8588**