



REFERRAL

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*“a **carf** accredited interdisciplinary pain rehabilitation program 2004 - 2017”*

Patient Name: _____ Date: ____/____/____

Patient Phone Home / Cell: _____ DOB: ____/____/____

Treating/Referring Physician: _____ DOI: ____/____/____

Compensable ICD-10 Diagnosis: _____

Evaluation for Interdisciplinary Pain Rehabilitation Program

- Functional restoration
- Individuals exercise routine specific to patient’s deficits
- Group therapy with pain process and stress management
- Vocational counseling / Job seeking skills
- Nutrition education
- Individual counseling
- Family Counseling
- Medication management
- Massage therapy
- Social skills development
- Pain coping strategies

Psychotherapy & Medication Monitoring Treatment Only

Work Hardening Clearance for Treating Physician

Psychological Surgical Clearance Procedure _____

Functional Capacity Evaluation

Work Hardening Program

Work Conditioning Program

Behavioral Health Assessment to Determine Appropriate Treatment

ODG Clinical Signs to Warrant Patient’s Participation in Interdisciplinary Pain Rehabilitation Program

- | | |
|---|--|
| <input type="checkbox"/> 300.82 (F45.1) somatic symptom disorder, severe, with predominant pain | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Previous methods of treating chronic pain have been unsuccessful | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Loss of ability to function independently resulting from chronic pain | <input type="checkbox"/> Sleep disturbance |
| <input type="checkbox"/> Patient is not a candidate where surgery would clearly be warranted | <input type="checkbox"/> Fear - Avoidance |
| <input type="checkbox"/> Medication dependence due to pain | <input type="checkbox"/> Insufficient Pain Coping Skills |
| <input type="checkbox"/> Patient has not met physical demand level | |
| <input type="checkbox"/> Isolation, lack of social interaction | |

SPECIAL INSTRUCTIONS

PHYSICIAN SIGNATURE



The following is a list of documents needed to process your referral:

- Completed and signed **referral**.
- Current **demographics** (patient, employer, and insurance information).
- Recent **doctor visit note** reflecting physical and psychological clinical indications reinforcing the need for the patient to participate in chronic pain program.
- A current **Functional Capacity Evaluation** report.
- **Physical therapy** notes, **work hardening** notes, and **work conditioning** notes (if the patient participated in such services).
- **Diagnostic reports** (MRI, CT Scans, Ultrasounds, X-Rays, ect).
- **Operative reports**, or specialist's note stating the patient is NOT a candidate for surgery.
- **Compensable ICD code(s)**.