Ann & Robert H. Lurie Children's Hospital of Chicago

Request for Chronic Pain Management Order

Patient Name:_____

DOB:_____

MRN (If available):_____

Parent Name_____

Phone #_____

Insurance: ☐ Medicaid, ☐ PPO, ☐ HMO, ☐ Self-pay / Other

*Please attach patient's demographics**

Referring Provider Name: _____

Practice Name: _____

Date of Request: _____

Step 1: When should patient be seen?

☐ First Available Appointment ☐ 1-2 Months ☐ 3+ Months

Step 2: Questions

Identify Chief Complaint(s) _____

Pertinent and Quick Patient History (1 – 2 sentences):

_____

_____

_____

Questions referring provider wants answered by Specialist:

_____

Has the referring provider already spoken with a Lurie specialist about this referral?

_____

Which location is preferred for the patient's appointment? Northbrook or Lurie Main Campus

_____

Please submit this request along with patient's pertinent medical records including: History & Physical, Imaging, Medications, Physical Therapy and Mental Health Records to Pain Management Fax #: 312.227.9730. Thank you!