

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

*Consultation Request Form*

**Administrative:**

Patient Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
Address: \_\_\_\_\_  
Patient Phone Number: \_\_\_\_\_ (work) \_\_\_\_\_ (home)  
Name of Insurer: \_\_\_\_\_  
Referring Physician Completing this form: \_\_\_\_\_  
Phone Number for Referring Physician: \_\_\_\_\_  
FAX Number for Referring Physician: \_\_\_\_\_

**Clinical:**

Pain Location (be specific): \_\_\_\_\_  
Current Pain Meds: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Previous Pain Meds: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Previous Injections or Procedures: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does the patient either a: Spinal Cord Stim and/or Intrathecal Pump: \_\_\_\_\_  
• Current therapy or past therapy (circle one) \_\_\_\_\_ (medication)

H/O Addiction or Substance Abuse: Yes No (circle one)  
• If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_  
• Where did patient complete substance abuse treatment: \_\_\_\_\_  
\_\_\_\_\_

Type of consultation request: (circle one)  
• Specific need: \_\_\_\_\_  
\_\_\_\_\_  
• General consultation

***This form will be reviewed by one of our physicians and your patient will be called for an appointment. If there are any problems or questions, we will contact you. Thank you.***