The Lemons Center
FOR BEHAVIORAL PAIN MANAGEMENT

PATIENT REFERRAL

Patient Name: _____**Date**: _____

Patient Phone #(s): _____**DOB**: _____

Patient's Insurance Carrier: _____

If available, please also fax your patient's demographics sheet.
IT IS NOT NECESSARY TO FAX MEDICAL RECORDS AT THIS TIME.

___ Comprehensive Behavioral Pain Management Program
(Evaluation and Treatment)

Includes Behavioral Pain Management, Physical Therapy, and Medication Management

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Individual Evaluation and Treatment

___ Individual Behavioral Pain Management Psychological Services and/or Behavioral Pain Management/Stress Management Course

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Patient Diagnosis: _____**ICD-9**: _____

Physician's Name: _____

Physician's Phone _____ **Fax #** _____

Physician's Signature: _____

Comments_____

Please have the referring physician sign and fax to our office. **Thank you for this referral.**

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FAX: 913-383-3116