
MILLENNIUM  PAIN CENTER

Referral Form for Research

Patient's Name: _____ Date: _____

Street Address: _____ City: _____

Zip: _____

Home Phone: () _____ Cell: () _____

D.O.B. _____ Referring Physician: _____

Insurance: _____ Is this a work comp case? Yes No

Referring Physician: _____ Phone: _____
Fax: _____

DX: _____

Please include the following items in your faxed referral:

- Any imaging for diagnostic assessment including MRI's, EMG's, CT's, Xrays, discograms ect.
- Any procedures/treatments related to pain therapy including injections and pain medications
- Current medications (including OTC medications, herbal supplements, etc.)
- Basic medical history and diagnosis

Please complete this form and fax it to the attention of Research at 309-661-4815. Please advise patient that a full eligibility review will be required to indicate if a patient may be eligible for a study. Please provide a name and number where we may reach you in case of any questions or feedback. Also, feel free to contact us with any questions!

Millennium Pain Center-Research
1015 S Mercer Ave.
Bloomington, IL. 61701
Phone: 309-662-4321 Fax: 309-661-4815