Yamhill Community Care Organization
Your Local Health Partner

Persistent Pain Program

811 NE 3rd Street McMinnville, OR 97128 Phone # 503-376-7426 Fax # 503-857-0767

Referral Form

Patient Information:

Name: ____ DOB: _________________________

Address: _____________________________City/State/Zip____________________________

Phone: __________________________ Medicaid ID# ________________________________

Referring Provider Information:

Name: ___________________________ Agency: ____________________________________

Phone: _______________________ e-mail: ____

Dx: _______________________________ ICD-9/10 code: ______________________________

As part of our treatment includes participation in physical activities designed to increase range of motion, flexibility, strength and endurance. All activities are low impact and are tailored to the individual**. Are there any medical factors in your patient's history or any medications that are currently being taken which would prevent them from participating in this supervised program? YES / NO**

If yes, please include explanation, recommendations or restrictions on an additional piece of paper.

Is patient aware of referral? YES / NO

Known history of substance abuse and/or positive screening results: YES / NO

- **Check here to request oversight committee review.** This is a panel of experts who would review patient's file and make recommendations for medication management. If checked, include most recent MRIs, chart notes, mental health history, and pertinent clinical information.

Provider signature: ____________________________________ Date: __________________________

Please make sure Authorization to Disclose Protected Information is signed and returned with referral along with any relevant chart notes.

Thank you for your referral!