TEXAS PAIN CENTERS
3519 TOWN CENTER BLVD, SUITE B
SUGAR LAND, TX 77479
PHONE: 832-730-PAIN (7246)
FAX: 844-302-5696

Veena Basava, MD

Thank you for referring your patient to the Texas Pain Centers. Please complete the information below and fax to **844-302-5696** or e-mail it to **staff@texaspaincenters.org**.

Patient Name: - ____

Phone No: - ____________________ **Date of birth: -** ____________________

Insurance: -____

Referring Provider: -________________**Phone: -**____________**Fax: -** ____________

Reason for Referral
(Please indicate the primary reason for the referral by checking either office evaluation or procedure)

☐ **Office Evaluation**

Transfer of Opioid care? ☐ **Yes** ☐ **No**

If **Yes**, please list medication and dosage:-

Medication	Dosage

Date of the last script: ____________________

☐ **Procedure**

What procedure? ____

Is the patient on any anticoagulant? ☐Yes ☐ No

If Yes Please list: -

____

Please include patient's demographic sheet, last 2 office visit notes, labs or diagnostic/imaging results, copy of medical insurance card and photo ID.