



A Division of OnCall Healthcare

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## Top Rated Pain Management Program Welcoming New Patients

### What is a Pain Medication Management Program?

OnCall Pain's Medication Management Program helps patients develop a personalized pain medication treatment plan that manages their painful issues. Our goal is to achieve a plan that gives our patients the best quality of life and allows them to be as active as possible while being monitored and followed in a comprehensive pain management program.

### About Us

Your OnCall Pain team has been in business for over 12 years specializing in pain management. Re-imagined in 2018, OnCall Pain is the modernized version of a previous brick and mortar pain clinic. We combined technology with decades of experience and rethought what pain management should be...

Simple, accessible, professional and affordable.

### Patient Benefits

- Individualized treatment plans
- Visit with a provider from the comfort of your home
- Take less time off work and spend less time driving to appointments
- Reduce costs & flexible scheduling
- Better access to your healthcare provider(s)
- Highest quality healthcare - don't take our word, visit our website & read our reviews

### For Additional Information

Check out our website, follow us on social media or chat with our Support Staff.

**Website:** [www.oncallpain.com](http://www.oncallpain.com)  
**Facebook:** [www.facebook.com/OnCallPain](http://www.facebook.com/OnCallPain)  
**Instagram:** [www.instagram.com/oncallpain/](http://www.instagram.com/oncallpain/)

#### OnCall Pain

Arizona | Colorado | Idaho | Oregon | New Mexico | Washington

Call: 602-345-0647 | Text: 602-403-2110

Fax: 888-518-4950 | Email: [pain@oncallhc.com](mailto:pain@oncallhc.com)

Visit us Online: [www.oncallpain.com](http://www.oncallpain.com)

Regular Business Hours: M-F 8am to 5pm MST



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## Referral Form

If you have a patient(s) that you would like to refer for pain management or medication management, please fax the following information to (888) 518-4950:

Patient Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Phone #: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Email: \_\_\_\_\_

Please fax a copy of the following:

- Patient's demographic and/or face sheet
- Last 3 or most recent visit notes
- History and physical
- Recent labs
- Any pertinent imaging

Referred by: \_\_\_\_\_  
Medical Group: \_\_\_\_\_  
Phone #: \_\_\_\_\_  
Fax #: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Email: \_\_\_\_\_

**We Appreciate Your Referral**

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