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Date: _____

Patient Name: _____ SS#: _____

Patient Address: _____

DOB:_____ Home Phone #:_____ Work Phone #: _____

Insurance: _____

Previous Pain Clinic: Yes__ No__ Workers Comp: Yes__ No__ W/C Phone #: _____

Reason for Referral/Pain Diagnosis: _____

_____

*** PLEASE FAX COPIES OF ANY DIAGNOSTIC REPORTS (MRI, CT, X-RAY, ETC.), AS WELL AS THE MOST RECENT PHYSICIAN'S NOTES, PATIENT DEMOGRAPHICS AND INSURANCE INFORMATION RELATED TO THE PATIENT ALONG WITH THIS REQUEST FORM. ***

❑ Pain Evaluation & Consultation or Evaluation & Treatment

❑ Diagnostic Nerve Block

❑ Epidural Steroid Injection
___cervical ___thoracic ___lumbar

❑ Facet Joint injection
___cervical ___thoracic ___lumbar

❑ Selective Nerve Root Block
___cervical ___thoracic ___lumbar

❑ Discography
___cervical ___thoracic ___lumbar

❑ Facet Rhizotomy

❑ Sacroiliac Joint Injection

❑ Kyphoplasty/Vertebroplasty

❑ Knee Joint/Hip Joint Injection

❑ Lumbar Sympathetic Block

❑ Occipital Nerve Block

❑ Stellate Ganglion Block

❑ Trial Spinal Cord Stimulator

❑ Trigger Point Injection

❑ Celiac Plexus Block

❑ Epidural Blood Patch

❑ Other _____

❑ Specific Level Desired (If applicable): _____

_____

Referring Physician:_____ Contact Telephone: _____

Referring Physician NPI#: _____