REFERRING PROVIDER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PRACTICE NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FAX:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT INFORMATION**

LAST NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FIRST NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M.I.\_\_\_\_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PATIENT PHONE #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OFFERED SERVICES INFORMATION NEEDED PRIOR TO APPT**

* Current progress notes with physicians referral
* Current imaging (within the last year) MRI/Xray
* Current lab work
* Medication List
* Demographics
* **Insurance information including a copy of patients insurance card(s**)

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Consultation with possibility of ongoing management

**(No Opioid Medications will be prescribed at initial appointment)**

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Consultation with recommendation for care plan

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Consultation with procedure as appropriate

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Procedure Only with follow up from Referring Provider

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| Procedures |  | Patient Diagnosis |
| Epidural Steroid Injection  | Cervical/Thoracic/LumbarLevel(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Selective Nerve Block or Transforaminal ESI | Left Right BilateralLevel(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Facet Joint Injections (with steroid) | Left Right BilateralLevel(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| SI Joint Injections w/Steroid or Anesthetic Only | Left Right BilateralLevel(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Occipital Nerve Blocks | Left Right Bilateral |  |
| Lumbar Sympathetic Block | Left Right Bilateral |  |
| Stellate Ganglion Block | Left Right Bilateral |  |
| Genicular Nerve Block | Left Right Bilateral |  |
| Intercostal Nerve Blocks | Left Right BilateralLevel(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Medial Branch Blocks ONLY | Left Right BilateralLevel(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Medial Branch Blocks w/subsequent RhizotomyInsurance Guidelines must be met prior to Rhizotomy | Left Right BilateralLevel(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Evaluation for Spinal Cord Stimulator | Cervical Lumbar |  |
| Evaluation for intrathecal drug delivery system |  |  |