NEBRASKA PAIN INSTITUTE

Getting you back to the good life

C. Weston Whitten, MD

Pain Management Specialist

NEW PATIENT REFERRAL FORM

4546 S 86th St, Suite B
Lincoln, NE 68526
Phone (402) 488-7246
Fax (402) 488-7247
NebraskaPainInstitute.com

Referring Physician: _____
Office Phone #: _____
Office Fax #: _____
Office Contact Person: _____

Patient name: _____ DOB _____ SSN _____
Best Contact Phone #: _____ Primary Insurance: _____
Pain-related diagnosis: _____
Specific Instructions: _____

Requested Procedures and/or Treatment

- ☐ Pain Management Evaluation and Treatment
- ☐ Selective Nerve Root Block
  ____Lumbar ____Cervical
- ☐ Epidural Steroid injections
  ____Lumbar _____Cervical
- ☐ Facet Injections/Medial Branch Block
- ☐ Evaluation for Spinal Cord Stimulator
- ☐ Kyphoplasty
- ☐ Discogram
- ☐ Sacroiliac Joint Injection
- ☐ Celiac Plexus Block
- ☐ Peripheral Nerve Block
- ☐ Radiofrequency Ablation
- ☐ Other_____

Follow up with

- ☐ Dr. Whitten
- ☐ Referring Physician

To facilitate the referral process, please fax this completed form, along with:

- ☐ **Copy of front and back of patient's insurance card(s) (must be received prior to review of information)**
- ☐ Copies of 2-3 most recent office notes
- ☐ Copies of any XRay/MRI/CT reports that are related to the patient's pain symptoms

We will make initial contact with the patient within 24 hours after receiving the information. If we do not feel that we can help your patient, our office will contact your office to let you know. Please list email address that we may send that information to _____

Thank you for the referral! We appreciate the opportunity to share in your patient's care.