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REFERRAL TO INTERVENTIONAL PAIN MANAGEMENT

PLEASE FAX THIS COMPLETED FORM ALONG WITH OFFICE NOTES, IMAGING, AND STUDIES TO 410-946-8360.

REFERRING PHYSICIAN/PROVIDER:

PHYSICIAN'S NAME: _____ PRACTICE NAME: _____

DATE: _____ PHONE: _____ FAX: _____

PATIENT INFORMATION:

LAST NAME: _____ FIRST NAME: _____ MIDDLE INITIAL: _____

DATE OF BIRTH: _____ PHONE: _____

SERVICES:

- CONSULTATION ONLY
 - REFERRAL WITH ONGOING MANAGEMENT
 - CONSULTATION WITH PROCEDURE AS APPROPRIATE
 - PROCEDURES ONLY
- (PLEASE INDICATE PROCEDURE FROM THE LIST BELOW)

PROCEDURE ONLY:

- EPIDURAL STEROID LEVEL _____
- TRANSFORAMINAL EPIDURAL LEVEL _____
SIDE: R _____ L _____
- FACET JOINT INJECTION LEVEL _____
SIDE: R _____ L _____
- TRIGGER POINT INJECTION
AREA: _____
- DISCOGRAM
AREA: _____
- NEUROSTIMULATION (SPINAL CORD & PERIPHERAL)
- INTRATHECAL DRUG DELIVERY
- OTHER (PLEASE SPECIFY)

DIAGNOSIS:

- CHRONIC BACK AND LEG PAIN
- FAILED BACK SURGERY SYNDROME
- COMPLEX REGIONAL PAIN SYNDROME (RSD/CAUSALGIA)
- POSTLAMINECTOMY PAIN SYNDROME (CERVICAL & LUMBAR)
- RADICULOPATHY
- MALIGNANT (CANCER) PAIN
- ARACHNOIDITIS
- NEURALGIA
- NEUROPATHIC PAIN
- CHRONIC PAIN SYNDROME
- OTHER: _____

FOLLOW UP CARE:

- I WOULD LIKE TO SEE THIS PATIENT FOR A FOLLOW-UP APPOINTMENT AFTER THE PROCEDURE
- I AM REFERRING THE PATIENT FOR LONG-TERM CARE

OFFICE NOTES:

OUR OFFICE WILL CONTACT YOUR PATIENT WITHIN 24 HOURS TO SCHEDULE AN APPOINTMENT