

## Request for Pain Management Consultation

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

Contact Phone #: \_\_\_\_\_

Insurance: \_\_\_\_\_

Major Insurance: \_\_\_\_\_

Medicare  Wellmed  Letter of Protection  None/Self-Pay

Chief Complaint / Diagnosis: \_\_\_\_\_

Referring Provider: \_\_\_\_\_

Office Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Referral Type:  Consultation and Treatment OR  Specific Request (check box below)

### If specific request, please check box or notate below:

- |   |   |
|---|---|
| <input type="checkbox"/> Spinal Cord Stimulator (Trial / Implant)                 | <input type="checkbox"/> Genicular Nerve Blocks / Radiofrequency Ablation |
| <input type="checkbox"/> Peripheral Nerve Stimulator (Trial / Implant)            | <input type="checkbox"/> Botox Injections for Migraines                   |
| <input type="checkbox"/> Dorsal Root Ganglion (DRG) Stimulator (Trial / Implant)  | <input type="checkbox"/> Kyphoplasty / Vertebroplasty                     |
| <input type="checkbox"/> Epidural Steroid Injection(s) (Cervical/Thoracic/Lumbar) | <input type="checkbox"/> Peripheral Nerve Block(s)                        |
| <input type="checkbox"/> Facet / Medial Branch Blocks (Cervical/Thoracic/Lumbar)  | <input type="checkbox"/> Selective Nerve Root Block(s)                    |
| <input type="checkbox"/> Stellate Ganglion Sympathetic Block                      | <input type="checkbox"/> Trigger Point Injection(s)                       |
| <input type="checkbox"/> Adhesiolysis   | <input type="checkbox"/> Occipital Nerve Block(s)                         |
| <input type="checkbox"/> Radiofrequency Ablation/Neurolysis                       | <input type="checkbox"/> Lumbar Sympathetic Block                         |
| <input type="checkbox"/> Sacroiliac Joint Injection(s)                            | <input type="checkbox"/> Platelet Rich Plasma / Prolotherapy              |
| <input type="checkbox"/> Joint Injection(s)                                       | <input type="checkbox"/> Vertiflex / Superior Procedure                   |
| <input type="checkbox"/> Ketamine Infusion  | <input type="checkbox"/> Medical Cannabis (note indication below)         |

Please note any further details, specific requests, joints, and/or levels: \_\_\_\_\_

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## Please fax this form to 512-981-7246

Please include any pertinent records, reports, and demographics.

Thank you for referring to the Diagnostic Pain Center!

Want more options? Check out [diagnosticpaincenter.com/referrals](http://diagnosticpaincenter.com/referrals) or scan here:

