



Please fax this document to (972) 833-7256

Name:		<input type="checkbox"/> Male <input type="checkbox"/> Female	
DOB:		Phone:	
Insurance:	Plan/ID#:	Group#:	
Claim#:	Claim Manager & Phone#:		
Diagnosis / Brief Pain History:			

In order to expedite scheduling this patient, kindly fax all of the following information. We will schedule the patient once all information is received, verified and reviewed.

- Referral form completed IN ITS ENTIRETY
- Legible copies of patients insurance cards (both sides)
- Most recent clinical/progress notes, pertaining to the referred diagnosis
- List of current medications
- Current diagnostic testing workup and imaging reports

Referring Provider Information

Name:		NPI#:	
Address:	City:	ST:	Zip:
Phone:		Fax:	

Services Requested

- Pain Consultation (opinion only)
- Pain Referral & Treatment (If treatment is to be turned over to us)
- Interventional procedure
 - Epidural injection
 - Joint injection
 - Selective/diagnostic nerve root block
 - Radiofrequency ablation
 - Electro diagnostic study (EMG/NCS). Extremities to be tested? RUE LUE RLE LLE
 - Other areas you would like to have assessed

- Botox for migraines, cervical dystonia or spasticity
- Neuromodulator (spinal cord stimulator trial)
- Sympathetic blocks
 - Stellate Lumbar Superior Hypogastric Plexus Ganglion of Impar
- Intercostal nerve blocks

Other: