Board Certified
Fellowship Trained
Interventional Pain Specialists

DIAGNOSTIC PAIN CENTER

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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:

□ Spinal Cord Stimulator (Trial / Implant)
□ Peripheral Nerve Stimulator (Trial / Implant)
□ Epidural Steroid Injection(s) (Cervical/Thoracic)
□ Epidural Steroid Injection(s) (Lumbar)
□ Facet / Medial Branch Blocks (Cervical/Thoracic)
□ Facet / Medial Branch Blocks (Lumbar)
□ Radiofrequency Ablation/Neurolysis
□ Sacroiliac Joint Injection(s)
□ Joint Injection(s)
□ Stellate Ganglion Sympathetic Block
□ Genicular Nerve Blocks / Ablation
□ Botox Injections for Migraines
□ Peripheral Nerve Block(s)
□ Selective Nerve Root Block(s)
□ Trigger Point Injection(s)
□ Occipital Nerve Block(s)
□ Lumbar Sympathetic Block
□ Hypogastric Plexus Block
□ Superion Procedure
□ Other

Please note any further specific requests, joints, and/or levels: _____

Please fax this form to our office along with any pertinent records, reports, and demographics.

We will follow up with the patient.

Fax #: 512-981-PAIN (7246)

Thank you for referring to the Diagnostic Pain Center!