UNIVERSITY SPINE AND PAIN CENTER
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PAIN SPECIALIST REFERRAL

PATIENT'S NAME: _____ PATIENT'S DOB:_____

PATIENT'S HOME & CELL PHONE: _____ TODAY'S DATE: _____

CONSULTS REQUESTED (Please check all that apply):

☐ **Evaluation & Management** ☐ **Medication Management** - ☐Addiction/Physical Dependency ☐ Pre-op ☐ Post-op

☐ **Consult & Return to referring Dr.** ☐ **Procedure & Management** ☐ **Procedure ONLY**

Discography
☐ Cervical Levels: _____
☐ Thoracic Levels: _____
☐ Lumbar Levels: _____

Epidural Steroid Injection
☐ Cervical ☐ Interlaminar ☐ Transforaminal
☐ Thoracic ☐ *Level:*_____ ☐ *Rt* ☐ *Lt*
☐ Lumbar ☐ Caudal ☐*Bilateral* ☐ *Level:* _____

☐ Selective Nerve Root Block ☐ Facet Nerve Block ☐ Facet Joint Steroid Injection ☐ Facet Radiofrequency Ablation
☐ *Cervical* ☐ *Rt* ☐ *Lt*
☐ *Thoracic* ☐*Bilateral* ☐ *Level:* _____
☐ *Lumbar*

Sympathetic Block
☐ Stellate ☐ Lumbar
☐ Celiac ☐ Impar Ganglion ☐ *Rt* ☐ *Lt*
☐ Hypogastric ☐*Bilateral*
☐ Other: _____

☐ Spinal Cord Stimulator
☐ Intrathecal Pump
☐ Trial
☐ Implant

☐ Kyphoplasty/Vertebroplasty ☐ Blood Patch ☐ Peripheral Nerve Block: _____
Level: _____ ☐ SI Joint Injection ☐ *Rt* ☐ *Lt* ☐ Hardware Injection: _____

☐ Joint Injection: _____
☐ Steroid ☐ Hyaluronic Acid ☐ Platelet Rich Plasma (PRP) ☐ Stem Cell ☐ Other :_____

☐ OTHER:_____

DOCTOR:_____

ADDRESS:_____

PHONE: _____ FAX:_____

Signature: _____