Northwest Pain Care, Inc

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Pain Medicine Referral Request

Please include patient's demographics page and recent chart notes with this transmittal.

Patient Name_____ DOB_____

Services Requested

☐ Consultation with recommendations only
☐ Consultation with ongoing treatment
☐ One time consultation with injection*
☐ Diagnostic injection for surgical decision making

*Injection will be scheduled on different day than consultation.

Procedure

All patients will be evaluated for appropriate intervention, with the exception of surgical diagnostic blocks.

☐Epidural Steroid Injection
☐Transforaminal ☐ Interlaminar ☐Caudal
Side: ☐ Right ☐ Left ☐ Bilateral
Level: _____

☐Facet Joint Injection
Side: ☐ Right ☐ Left ☐ Bilateral
Level: _____

☐ Selective Nerve Root Block
Side: ☐ Right ☐ Left
Level: _____

☐ Sacroiliac Joint Injection **
Side: ☐ Right ☐ Left

☐ Botox injections for Migraines
☐ Neurostimulation
☐ Intrathecal Drug Delivery
☐ Kyphoplasty

*** Insurance only allows one side at a time*

Imaging Type

☐MRI: ☐ CERVICAL ☐THORACIC ☐ LUMBAR
Where: _____
When: _____

☐Xrays: ☐ CERVICAL ☐THORACIC ☐ LUMBAR
Where: _____
When: _____

☐Bone Scan: ☐ CERVICAL ☐THORACIC ☐LUMBAR
Where: _____
When: _____

Diagnosis

☐ Chronic low back pain
☐ Back pain with leg pain
☐ Right ☐ Left ☐ Bilateral
☐ Chronic neck pain
☐ Neck pain with arm pain
☐ Right ☐ Left ☐ Bilateral
☐ CRPS (RSD)
☐ Arm ☐ Leg
☐ Right ☐ Left ☐ Bilateral
☐ Cervicogenic Headache
☐ Right ☐ Left ☐ Bilateral
☐ Cancer Pain
Cancer type & Stage: _____
Prognosis (Mo, Yr): _____

Past Spine Surgical History:

Previous Back Surgery: ☐ Yes ☐ No
Type: _____
_____
When: _____
Levels: _____

Previous Neck Surgery: ☐ Yes ☐ No
Type: _____
_____
When: _____
Levels: _____

Other Comments: _____
_____
_____