INTEGRATED PAIN SPECIALISTS

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REFERRAL FORM

Date: _____

Total Pages: _____

REQUIRED: RECENT DOCTOR'S NOTES & RECOMMENDATIONS, IMAGING RESULTS & ANY OTHER PERTINENT INFORMATION

PATIENT INFORMATION:

NAME: _____ DOB: _____ PHONE: _____

ADDRESS: _____ CITY/STATE/ZIP: _____

E-MAIL (optional): _____

REFERRING PROVIDER INFORMATION:

NAME OF PROVIDER: _____

PHONE: _____ FAX: _____

NAME OF PERSON COMPLETING THIS FORM: _____

REASON FOR REFERRAL:

CPT CODES TO USE: CONSULT: 99204 FOLLOW-UP: 99214

- ❑ CONSULTATION ONLY
- ❑ CONSULT + TREAT
- ❑ FOLLOW-UP + TREAT
- ❑ TRANSFER OF CARE: PAIN / MEDICATION MANAGEMENT (FOR WORKERS' COMP: SECONDARY TREATER ONLY)
- ❑ FOLLOW-UP + INJECTION / PROCEDURE (SPECIFY BELOW)

RECOMMENDED PROCEDURE:

- ❑ EPIDURAL STEROID INJECTION
- ❑ SELECTIVE NERVE ROOT BLOCK
- ❑ FACET JOINT INJECTION
- ❑ MEDIAN BRANCH BLOCKS
- ❑ RADIOFREQUENCY ABLATION
- ❑ SACROILIAC JOINT INJECTION
- ❑ STELLATE GANGLION BLOCK
- ❑ OCCIPITAL NERVE BLOCK
- ❑ TRIGGER POINT INJECTION
- ❑ INTRATHECAL PAIN PUMP
- ❑ SPINAL CORD STIMULATOR
- ❑ PERIPHERAL NERVE STIMULATOR

INDICATE LEVEL:

- ❑ BILATERAL
- ❑ RIGHT
- ❑ LEFT
- ❑ N/A
- ❑ CERVICAL
- ❑ THORACIC
- ❑ LUMBAR
- ❑ SACRAL

LEVEL(S): _____

- ❑ DIAGNOSTIC
- ❑ THERAPEUTIC

❑ OTHER PROCEDURE: _____

DIAGNOSIS: _____

INSURANCE INFORMATION:

PLEASE CHECK ONE: ❑ HMO ❑ PPO ❑ W/C ❑ PI LIEN ❑ MEDICARE

INSURANCE CARRIER: _____ PHONE: _____

CLAIM / ID #: _____ GROUP / DOI: _____

ADDRESS/MEDICAL GROUP: _____

AUTHORIZATION #: _____ EXPIRES: _____ ❑ AUTH ATTACHED