Michigan Interventional Pain Associates

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Date:_____

Patient Name:_____ DOB:_____

PROCEDURE (check those that apply)

DIAGNOSIS FOR PROCEDURE:_____

☐ TRANSFORAMINAL EPIDURAL STEROID INJECTION ▶ LEVEL:_____ ☐ RIGHT ☐ LEFT ☐ BILATERAL
☐ INTERLAMINAR EPIDURAL STEROID INJECTION ▶ ☐ LUMBAR ☐ CERVICAL ☐ THORACIC
☐ CAUDAL EPIDURAL STEROID INJECTION
☐ FACET STEROID INJECTION ▶ LEVEL:_____ ☐ RIGHT ☐ LEFT ☐ BILATERAL
☐ MEDIAL BRANCH BLOCK ▶ LEVEL:_____ ☐ RT ☐ LT ☐ BILAT ☐ LUMBAR ☐ CERVICAL
☐ FACET JOINT RHIZOTOMY ▶ LEVEL:_____ ☐ RT ☐ LT ☐ BILAT ☐ LUMBAR ☐ CERVICAL
☐ SI JOINT STEROID INJECTION ▶ ☐ RIGHT ☐ LEFT ☐ BILATERAL
☐ SI JOINT RHIZOTOMY ▶ ☐ RIGHT ☐ LEFT ☐ BILATERAL
☐ HIP INJECTION ▶ ☐ RIGHT ☐ LEFT ☐ BILATERAL
☐ SPINAL CORD STIMULATOR TRIAL ▶ DIAGNOSIS:_____
☐ OTHER: _____

REFERRING PHYSICIAN NAME:_____

REFERRING PHYSICIAN SIGNATURE:_____

OFFICE PHONE NUMBER:_____

*****THANK YOU FOR YOUR REFERRAL. TO EXPEDITE THE PROCESS AND ASSIST IN ANY NECESSARY PRIOR AUTHORIZATIONS, PLEASE FAX US A COPY OF YOUR PATIENT'S LAST OFFICE VISIT NOTE, DEMOGRAPHICS/INSURANCE, AND ANY WRITTEN REPORTS OF THEIR MRI-CT-XRAY. WE LOOK FORWARD TO CARING FOR YOUR PATIENT*****