# Advanced Pain Management Institute

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Patient Name: ______________________________ DOB: / /

Soc. Security: ______________ Home: ________ Cell/Work: ______________
Patient Insurance Plan: Does the referral require preauthroization?
Worker's Compensation? Y N

## Reason for the consult:

_________ Lumbar Vertebral Compression Fracture
_________ Thoracic Vertebral Compression Fracture
_________ Spinal Stenosis
_________ Lumbar Postlaminectomy Syndrome
_________ Lumbar Degenrative Disc Disease (LDDD)
_________ Cervical Degenerative Disc Disease (CDDD)
_________ Lumbar Radiculopathy (Sciatica)
_________ Cervical Radiculopathy
_________ Joint Pain (Arthritis) - shoulder/hip/knee
_________ Shingles/Zoster or Post Herpatic Neuralgia
_________ Back Pain
_________ Bursitis
_________ Cancer related Pain
_________ Intercostal Neuralgia
_________ Diabetic Peripheral Neuropathy
_________ Idiopathic Neuropathy
_________ Migraine/cluster Headache
_________ Trigeminal Neuralgia
_________ Face Pain
_________ Occipital Neuralgia
_________ Abdominal/Pelvic Pain
_________ Neck Pain
_________ Tail Bone pain (coccydynia)
_________ Other: _______________

## Intervnetional Procedures Requested:

_________ Kyphoplasty/Vertebroplasty
_________ Spinal Cord Stimulation
_________ Epidural Injection (Cervical/Thoracic/Lumbar)
_________ Facet Injections (Cervical/Thoracic/Lumbar)
_________ Trigeminal Nerve Block
_________ Sphenopalatine Ganglion Block
_________ Intrathecal Pump
_________ Neurolytic injections for cancer pain
_________ Bursa injections
_________ Intercostal Nerve Block
_________ Peripheral Nerve Block: _____________
_________ Spinal Cord Stimulator trial
_________ Stellate ganglion Block
_________ Lumbar Symapthetic plexus block
_________ Celiac Plexus Block
_________ Hypogastric Plexus Block
_________ Ilioinguinal nerve block
_________ Occipital Nerve block
_________ Sacrococcygeal Nerve Block
_________ Joint Injections (Steroid/Synvisc) (Elbow/Shoulder/Hip/Knee)
_________ Radiofrequency Nerve Ablation (Cervical/Thoracic/Lumbar)
_________ Other: ______________________

**Please fax/mail H&P or recent progress note along with any relevant imaging/EMG studies**

**Comments: (Optional)**

**Physician signature** _______________ **Physician name (please print)** _______________ **Date: / / .**

ITERNAL USE ONLY
Received:____/____/_____ Appointment made: ____/_____/_____