Consultation Request

1105 N Central Expressway
Suite 210
Allen, TX 75013
972-747-5842
Fax: 972-747-6033

From the Office of Dr. ______________________________ **Date:** ________________

Physician number____________________ **Fax number**_________________________

Patient Name: ________________ **Age** ______**Phone number**________________

Diagnosis/Symptoms: ____

Request for: ❑ EVALUATE and TREAT ❑ EVALUATE and RECOMMEND
Or ❑ **PERFORM SPECIFIC BLOCK(S):**

○ **Epidural Steroid Blocks:**
❑ Lumbar ❑ Cervical ❑ Thoracic ❑ Caudal. Level Desired:__________________
○ **Facet Blocks:**
❑ Lumbar ❑ Cervical ❑ Thoracic. Level Desired: _______________________
○ **Sympathetic Nerve Blocks:**
❑ Stellate Ganglion ❑ Lumbar Sympathetic ❑ I-V Regional Anesthesia/Bier block
○ **Other:**
❑ Selective Nerve-Root Block(s) cervical/ lumbar Level:_______________________

❑ Sacroiliac Joint Injection: ❑ Right ❑ Left ❑ Bilateral

❑ Peripheral Nerve Block(s): Location:______________________________________

❑ Trigger Point Injections. Area: ____

❑ Radio-Frequency Lesioning: Location: ____________________________________

❑ Discograms: Levels: ____

❑ Evaluate for Spinal Morphine/Dilaudid/Baclofen Pump Implant

❑ Evaluate for Spinal Dorsal Column Stimulator Implant

❑ Evaluate for Vertebroplasty/percutaneous discectomy

- Other: ____

COMMENTS: ____

Please fax this sheet with patient information, insurance information, authorization information and pertinent office notes and diagnostic reports to *Pain Medics* or call. We will notify the patient as soon as we process the request and we will notify your office via fax as soon as the patient is scheduled for treatment/consult. We appreciate your referrals. **Thank you.**