Center for
Pain Medicine

REFERRAL

Patient Name: _____
Date of Birth: _____
Address: _____
Phone Number: _____ Cell Number: _____

DIAGNOSIS: _____
Insurance: _____

Work Injury? ☐ Yes ☐ No

Reason for referral:

☐ Consult and treatment

☐ Procedure only:

__ Epidural Steroid injection
__ Transforaminal Epidural Injection
__ Selective Nerve Root Block
__ Hip Injection
__ Greater trochanteric injection
__ Sacroiliac Joint Injection
__ Medial Branch Blocks
__ Facet Joint Block
__Radiofrequency ablation
__Sympathetic Block
__Lumbar Discogram
__Trigger point Injections
__Occipital Nerve Block
__Intercostal Nerve Block
__Other: _____

__Trial/ implant of Spinal Cord Stimulator
__Trial/ Implant Pain Pump
__Trial/ Implant Baclofen Pump

Referring Provider: _____
Phone Number: _____
Fax Number: _____

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www.centerforpainfargo.com