Center for
Pain Medicine
Clinic & Surgery Center

REFERRAL

Please complete this form and fax with records to: 701-551-6984.

Patient Name: ______________________________
Date of Birth: _____________
Address: ____
Phone Number: _________________________ Cell Number: ______________________

DIAGNOSIS: _______________________________________

Insurance Name/Identification ID: ____

Work Injury? ☐ Yes ☐ No Claim # ________________________ Date of Injury: __________

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: _______________________

2401 41st Street South, Fargo, ND 58104-7783
Phone: 701-551-6980 Fax: 701-551-6984
www.centerforpainfargo.com