Center for Pain Medicine
Clinic & Surgery Center

REFERRAL

Please complete this form and fax with records including insurance information and medication list to: 701-551-6984. Thank you.

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

DIAGNOSIS: _____
Insurance Identification ID:_____

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

Is the patient a lock in with a PCP or Facility? ☐ Yes ☐ No
If yes, name of PCP/Facility: _____

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