HealthEast

PAIN CENTER
REFERRAL FORM

Patient Name_____ DOB_____ Home Phone_____

Address _____

Medical Diagnosis _____

Referring Clinic _____ Clinic Phone # _____

Referring Physician Name _____ Clinic Fax #_____

Interpreter needed? ☐ Yes ☐ No What Language? _____

☐ **Pain Consultation Requested:**
Comments _____

☐ **Behavioral Health Consultation Requested**

☐ **Acupuncture** ☐ **Occupational Therapy**

☐ **Pharmacist Consultation**

☐ **Procedure Requested: (Consultation not needed)**
- patient will return to referring provider

Procedure:

- ☐ Epidural Steroid Injection
- ☐ Selective Nerve Root Injection (diagnostic)
- ☐ Botox for chronic migraine
- ☐ Facet Joint Injection (Intra-Articular)
- ☐ Diagnostic Medial Branch Facet Nerve Blocks
- ☐ Other Nerve Block or Injection (Specify) _____

Specific Anatomic Location:

Cervical Level(s) _____

Lumbar Level(s) _____

Thoracic Level(s) _____

Specific Side(s):

☐ Right ☐ Left ☐ Bilateral

☐ **Joint:** ☐ Shoulder ☐ Elbow ☐ Wrist ☐ Knee Steroid ☐ Hip
☐ Knee - (Synvisc, Hyalgan) ☐ Sacroiliac

Evaluation for Procedure (To determine if the patient is a candidate for):

☐ Spinal Cord Stimulator ☐ Other (Specify) _____

Is the Patient on anticoagulants: ☐ Coumadin ☐ Platelet inhibitor _____ ☐ other _____

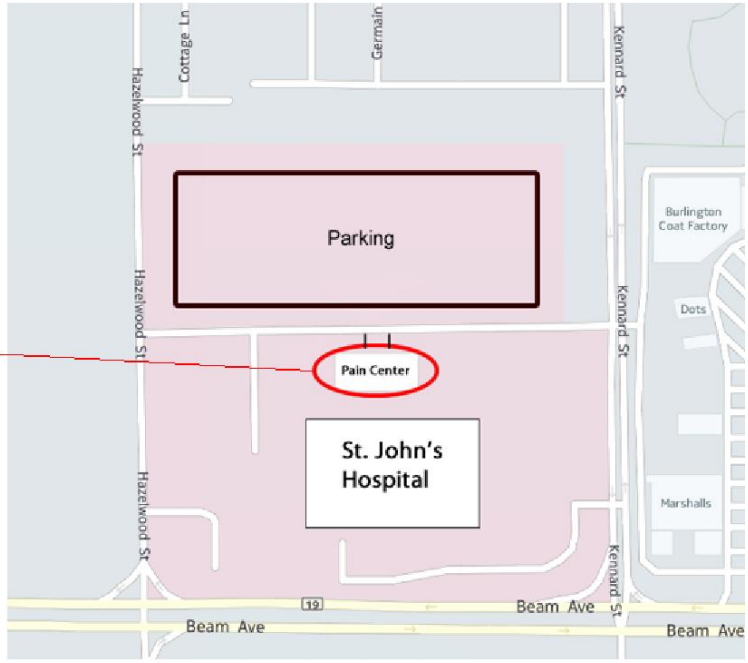
Referring Provider Signature: _____Date:_____

Please fax pertinent H&P, MRI/Radiology results, and current medication list along with referral form.

Fax: 651-232-5217 * for an appointment phone: 651-232-5354

Please note: Medications may/may not be prescribed at the initial visit

HealthEast®



HealthEast® Pain Center

1600 St. John's Blvd. Ste. 101 ● Maplewood, MN 55109

Ph: 651-232-5354

Fax: 651-232-5217