HOUSTON
PAIN & SPINE

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REFERRAL TO INTERVENTIONAL PAIN MANAGEMENT

Please fax this completed form along with office notes, imaging, and studies to 832.436.4050.

REFERRING PHYSICIAN

Physican Name: _____ Practice Name: _____

Date: _____ Phone: _____ Fax: _____

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: ____

Date of Birth: _____ Phone: _____

SERVICES

- ☐ Consultation only
- ☐ Referral with ongoing management
- ☐ Consultation with procedure as appropriate
- ☐ Procedures only
  (please indicate procedure from the list below)

PROCEDURE ONLY

- ☐ Epidural steroid Level: _____
- ☐ Transforaminal epidural
  Level side: R_____ L_____
- ☐ Facet joint injection
  Level side: R_____ L_____
- ☐ Trigger point injection
  Area: _____
- ☐ Discogram
  Area: _____
- ☐ Spinal Cord Stimulator
- ☐ Evaluation for Intrathecal Drug Delivery
- ☐ Other (please specify)

_____

_____

DIAGNOSIS:

- ☐ Chronic back and leg pain
- ☐ Failed back surgery syndrome
- ☐ Complex regional pain syndrome
- ☐ Regional sympathetic dystrophy
- ☐ Radiculopathy
- ☐ Malignant pain
- ☐ Arachnoiditis
- ☐ Neuralgia
- ☐ Other _____

FOLLOW-UP CARE

- ☐ I would like to see this patient for a follow-up appointment after the procedure.
- ☐ I am referring this patient to you for long-term care.

OFFICE NOTES

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Our office will contact your patient within 24 hours to schedule an appointment.