Medical Imaging Services
Coffeyville Regional Mecial Center
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PAIN MANAGEMENT PATIENT REFERRAL FORM

Referring Provider: _____

Referring Provider Phone: _____

Patient's name: _____

Patient's DOB: _____

Patient's phone number: _____

Proposed Procedure: _____ Cervical/Thoracic Epidural Injection ____ Lumbar Epidural Injection

_____ Major Joint Injection (Hip, Knee, Shd) ____ Sacroiliac Joint Injection

____Medial Branch Nerve Block _____ Nerve Block

_____ Other _____

Reason for referral: _____

_____

Pt has a history of, a physical exam **and** image-based radiological testing indicating one of the following: Lumbar, cervical or thoracic radiculopathy, radicular pain, neurogenic claudication, etc.

YES NO

Has patient had pain duration of at least 4 weeks and inability to tolerate noninvasive conservative care **OR** medical documentation of failure to respond to 4 weeks of non-invasive conservative care?

YES NO

Patient on blood thinners: YES NO

- If yes, it is ok to stop 3-5 days prior to procedure YES NO CHECK WITH CARDIOLOGIST

COMMENTS:

_____

_____

Referring Provider Signature _____ Date/Time_____

(Order good for one year from signed date)