



**Request for Consultation/Procedure(s)  
FAX THIS REFERRAL TO 770-948-6804**

**Patient's Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **SSN:** \_\_\_\_\_

**Insurance Company:** \_\_\_\_\_ **ID#:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**DIAGNOSIS:** \_\_\_\_\_

**REQUESTED PROCEDURE(S): Please Circle Requested Procedure**

**Consultation for Pain Management/ Evaluate and Treat**

**Epidural Steroid Injections:** Lumbar Cervical Thoracic Caudal: Single Injection Series of 3

**Lumbar Facet/Nerve Block:** Level \_\_\_\_\_ Side \_\_\_\_\_

**Cervical Facet/Nerve Block** Level \_\_\_\_\_ Side \_\_\_\_\_

**Radiofrequency Ablation Lumbar/Cervical Facet Nerves** Level \_\_\_\_\_ Side \_\_\_\_\_

**Selective Nerve Root Block** Level \_\_\_\_\_ Side \_\_\_\_\_

**SI Joint Injection** RT LT B/L Intercostal Nerve Block Side \_\_\_\_\_ Level \_\_\_\_\_

**Lumbar Sympathetic Block** RT LT B/L Stellate Ganglion Block RT LT B/L

**Provocative Discography** Levels \_\_\_\_\_

**Vertebroplasty/ Kyphoplasty Levels:** \_\_\_\_\_

**Spinal Cord Stimulation** Percutaneous Disc Decompression

**Implantable Drug Delivery System** Trigger Point Injections Site \_\_\_\_\_

**Other:** \_\_\_\_\_

**Referring Physician's Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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