



pain-MDs.com

**16222 N. 59th Avenue, Suite A-100
Glendale, AZ 85306
phone 602-298-PAIN (7246)
fax 623-236-9021**

HOURS

**Monday - Friday Saturday
7am - 7pm 8am - 1pm**

Patient Name: _____ **Patient Phone:** _____

Patient Insurance: _____

Referring Physician: _____ **Physician Phone:** _____

Clinic Name: _____

Comments: _____

PAIN & INJURY SERVICES

- | | |
|--|--|
| <input type="checkbox"/> Consultation & Treatment as Necessary | <input type="checkbox"/> Peripheral Nerve Injection _____ |
| <input type="checkbox"/> Consultation Only | <input type="checkbox"/> Sacroiliac Injection R___ L___ |
| <input type="checkbox"/> EMG / NCV Upper Extremities___ Lower Extremities___ | <input type="checkbox"/> Epidural Steroid Injection C___ T___ L___ |
| <input type="checkbox"/> X-Ray _____ | <input type="checkbox"/> Facet Injection C___ T___ L___ |
| <input type="checkbox"/> Physical Therapy _____ | <input type="checkbox"/> Medial Branch Block C___ T___ L___ |
| <input type="checkbox"/> Chiropractic | <input type="checkbox"/> RF Rhiz./Neuroablation C___ T___ L___ |
| <input type="checkbox"/> Trigger Point Injection _____ | <input type="checkbox"/> Manipulation Under Anesthesia |
| <input type="checkbox"/> Intra-articular Injection _____ | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Viscosupplementation Injection of Knee R___ L___ (Hyaluronic Acid Injections with Fluoroscopy) | |

If the insurance plan requires a referral or authorization, we will need this prior to scheduling the appointment. Thank you.

To ensure an easy referral for you and your patient, please also fax the following:

- Office visit notes from the last one to three visits
- Medication list
- Past diagnostic reports, if available (X-Ray, MRI, CT, or EMG)