PAINSOUTH

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Date: _____

Attention: ____Heather/Tammy_____

Referral from:_____

Referral Office phone number:_____

Patient Name: _____DOB: _____

Type of Appointment (Please Circle): __New Patient/Procedure_____

Same day procedure referral? (Please Circle) ___Y/N_____

Please Check the Type of Procedure Needed:

___LUMBAR EPIDURAL INJECTION
___CERVICAL EPIDIRAL INJECTION
___CAUDAL EPIDURAL INJECTION
___TRANSFORAMINAL
___FACET JOINT INJECTION
___RADIOFREQUENCY LESIONING
___SACROILIAC JOINT INJECTION
___HIP/JOINT INJECTION
___KNEE INJECTION
___ELBOW INJECTION
___SHOULDER INJECTION
___BLOOD PATCH
___SPINAL CORD STIMULATOR
___DISCOGRAM

Please attach:
PATIENT DEMOGRAPHICS
AVAILABLE MRI/XRAY
LAST OFFICE NOTE

**If this is a directed procedure referral,
please include the patient's current medications**

Thank you for your referrals!
We look forward to treating your patients!