

# PAIN SOUTH

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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 EPIDURAL 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!*