Oklahoma Interventional Spine & Pain

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REQUEST CONSULTATION AND RECOMMENDATIONS FOR:

PATIENT: _____ DATE: _____

PATIENT PHONE NUMBER: _____

INSURANCE: _____

PROBLEM:

❑ Low Back Pain ❑ Arm Pain ❑ Other _____

❑ Leg Pain ❑ Extremity Numb/Tingle ❑ Chronic Pain Med Mngmt.

STUDY REQUESTED: (EMG/Nerve Conduction Studies)

❑ Carpal Tunnel Screen ❑ Left ❑ Right ❑ Bilateral

❑ Cervical Radiculopathy ❑ Left ❑ Right ❑ Bilateral

❑ Lumbar Radiculopathy ❑ Left ❑ Right ❑ Bilateral

❑ Other _____

PROCEDURE REQUESTED:

❑ Spine Injections (epidurals, facet injections, etc.) ❑ Spinal cord stimulator ❑ Suboxone

❑ Sacroiliac joint injections ❑ Ketamine

REFERRING PHYSICIAN (Please Print): _____

SIGNATURE OF REFERRING PHYSICIAN: _____

PHONE: _____ FAX: _____

Thank you. Please fax to (918) 728-8019.

PLEASE INCLUDE: ❑ Front/Back of Insurance Card ❑ Last Two Office Notes

❑ Current Medication List ❑ Imaging Reports

Visit us at okspinepain.com.