Advanced Pain & Spine Institute
COMMUNITY MEDICAL CENTER

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AdvancedPainAndSpine.com

Please complete this form and fax to: 406.721.8298

*In order to schedule your patient please include the last six months or pertinent medical and imaging records.

SERVICES

- ☐ **CHRONIC PAIN MANAGEMENT:** Please evaluate the patient in your multidisciplinary program with physical therapy, pain psychotherapy, interventional pain procedures and possible medication management. **We do not prescribe pain medication on first visit and patient must pass our pain medication protocol in order to be prescribed if that is deemed an option.**
- ☐ **SPINE REFERRAL:** A multidisciplinary approach to spine care including physical therapy, pain and interventional medicine, neurosurgery or orthopedic surgery, psychotherapy and diagnostic imaging studies.
- ☐ **CONSULTATION WITH PROCEDURE AS APPROPRIATE:** An evaluation for interventional pain procedures. (Please check desired choice if known)
- ☐ **ONE TIME PAIN CONSULTATION:** Recommendations for how we can treat this patient in our clinic.

INTERVENTIONAL PAIN PROCEDURES
(Must be pre-authorized)

DX: _____

- ☐ Interlaminar Steroid Level: _____
- ☐ Transforaminal Epidural Level Side: R _____ L _____
- ☐ Selective Nerve Root Block Level Side: R _____ L _____
- ☐ Facet Joint Injection Level Side: R _____ L _____
- ☐ SI Joint Injection R _____ L _____ BIL _____
- ☐ Radio Frequency Ablation
- ☐ Medial Branch Blocks
- ☐ Other (Please specify) _____

Referring Physician | Office Contact | Phone | Fax

PATIENT INFORMATION

Name | DOB | Phone #

Address | City | State | Zip

INSURANCE INFORMATION

☐ **PRE-PROCEDURE INSTRUCTIONS GIVEN**

Primary Insurance | Policy/Claim # | Group # | Adjuster

Secondary Insurance | Policy/Claim # | Group # | Adjuster

WORK RELATED? YES / NO AUTO INJURY? YES / NO DATE OF INJURY _____/_____/_____

EMPLOYER:_____ STATE OF INJURY: _____

HAS PATIENT HAD RECENT:

MRI YES NO Where/When _____

X-RAY YES NO Where/When _____

CT YES NO Where/When _____

IS PATIENT TAKING: Antibiotics? YES / NO

Blood Thinners? YES / NO : _____

DOES PATIENT HAVE: Liver Problems? (Hep C) YES / NO Diabetes? YES / NO

Allergy to Contrast Dye, Latex, Iodine or Shellfish? YES / NO

DUE TO WEIGHT RESTRICTIONS AT CERTAIN FACILITIES, PLEASE INDICATE PATIENT'S EXACT WEIGHT: