Interventional Pain Management

McKinney Spine and Pain Center

Ease the Pain and Live Your Life

REFERRAL FORM

(You may choose to fill out this form on our website)

REFERRING PHYSICIAN ____

Date___________________________ URGENT ________Yes ☐ No ☐

PATIENT NAME ____

Phone __________________________ **Email**______________________________________

☐ **Consultation Only**

☐ **Evaluate and Treat:** ☐ Neck Pain ☐ Lower Back Pain ☐ Fibromyalgia

☐ Failed Back Surgery Syndrome ☐ Manage Chronic Pain Medicines

☐ Other __________________________________

☐ **Evaluate and Consider:** ☐ Trigger Point Injection ☐ Occipital Nerve Block

☐ Sacro-Iliac Joint Injection ☐ Epidural Steroid Injections

☐ Caudal Epidural Lysis of Adhesion/RAcz Procedure

☐ Other _______________________________

INSURANCE

PRIMARY____

SECONDARY____

PLEASE FAX A COPY OF PATIENTS INSURANCE CARD FRONT AND BACK, ANY MRI, CT OR X-RAY REPORTS, LAST FEW FOLLOW UP NOTES, MEDICATION LIST AND ANY OTHER INFORMATION PERTAINING TO THIS REFERRAL. THANK YOU.

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