



Michigan Interventional Pain Associates

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Board Certified, American Board of Anesthesiology
Subspecialty Certification in Pain Medicine

Date: _____

Patient Name: _____ DOB: _____

PROCEDURE (check those that apply)

DIAGNOSIS FOR PROCEDURE: _____

- TRANSFORAMINAL EPIDURAL STEROID INJECTION ► LEVEL: _____ RIGHT LEFT BILATERAL
- INTERLAMINAR EPIDURAL STEROID INJECTION ► LUMBAR CERVICAL THORACIC
- CAUDAL EPIDURAL STEROID INJECTION
- FACET STEROID INJECTION ► LEVEL: _____ RIGHT LEFT BILATERAL
- MEDIAL BRANCH BLOCK ► LEVEL: _____ RT LT BILAT LUMBAR CERVICAL
- FACET JOINT RHIZOTOMY ► LEVEL: _____ RT LT BILAT LUMBAR CERVICAL
- SI JOINT STEROID INJECTION ► RIGHT LEFT BILATERAL
- SI JOINT RHIZOTOMY ► RIGHT LEFT BILATERAL
- HIP INJECTION ► RIGHT LEFT BILATERAL
- SPINAL CORD STIMULATOR TRIAL ► DIAGNOSIS: _____
- OTHER: _____

REFERRING PHYSICIAN NAME: _____

REFERRING PHYSICIAN SIGNATURE: _____

OFFICE PHONE NUMBER: _____

*****THANK YOU FOR YOUR REFERRAL. TO EXPEDITE THE PROCESS AND ASSIST IN ANY NECESSARY PRIOR AUTHORIZATIONS, PLEASE FAX US A COPY OF YOUR PATIENT'S LAST OFFICE VISIT NOTE, DEMOGRAPHICS/INSURANCE, AND ANY WRITTEN REPORTS OF THEIR MRI-CT-XRAY. WE LOOK FORWARD TO CARING FOR YOUR PATIENT*****