ADVANCED PAIN
INSTITUTE OF TEXAS

PATIENT REFERRAL FORM

Requesting Provider _____

Your Phone # (_____) _____ **Your Fax #** (_____) _____

Patient Name _____ **Patient Phone #** (_____) _____

1. Please attach all the patient information requested below:

- ☐ Patient Demographics
- ☐ Copy of the insurance cards
- ☐ Diagnostic Reports (MRI/CT/Xrays/EMG
- ☐ Pertinent Notes or Labs
- ☐ Medication List

2. Fax all documents to our office at (972) 866-4249, and please inform your patients they will be contacted by our office.

Type of pain for evaluation and treatment:

- ☐ **Spinal Pain**
  - ○ Cervical
  - ○ Thoracic
  - ○ Lumbar
- ☐ **Joint Pain**
  - ○ Knee
  - ○ Shoulder
  - ○ Hip
  - ○ Elbow/Wrist/Hand
  - ○ Foot
- ☐ **Myofascial Pain**
- ☐ **Other** _____

Requested services, if applicable:

- ☐ Evaluation and treatment
- ☐ Trigger point injections
- ☐ Interlaminar cervical/thoracic/lumbar epidural steroid injections
  specify level if desired _____
- ☐ Transforaminal epidural steroid injections at level _____
- ☐ Facet joint injections/cervical/thoracic/lumbar/medial branch blocks/radio frequency lesioning
  specify level if desired _____
- ☐ Spinal cord stimulator
- ☐ Vertebroplasty/kyphoplasty
- ☐ Discogram
- ☐ Nerve Block _____
- ☐ Lumbar sympothetic block
- ☐ Stellate ganglion block
- ☐ Genicular nerve block
- ☐ Other _____