Injection Referral

COLORADO PAIN & REHABILITATION

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Colorado Pain & Rehabilitation
www.copainandrehab.com

Patient Information

Name:_____ DOB:____/____/____ Home Phone: (____) ____-____
Diagnosis:_____ Cell Phone: (____) ____-____
Work Phone: (____) ____-____
Symptoms:_____

Diagnostic & Therapeutic Injections

☐ Cervical_____ ☐ Thoracic_____ ☐ Lumbar_____

☐ Left ☐ Right ☐ Bilateral

☐ Transforaminal Epidural Injection
☐ Translaminar Epidural Injection
☐ Selective Nerve Root Injection
☐ Anesthetic ONLY (Diagnostic)
☐ Steroid & Anesthetic (Therapeutic)
☐ Facet Injection
☐ Medial Branch Nerve Blockage
☐ Radiofrequency Neuroablation
☐ Hip Injection
☐ SI Joint Injection
☐ Discography
☐ Control:_____
☐ Provocation:_____
☐ Other:_____

Referred By:_____ Phone #: (____) ____-____
Physician Signature:_____MD/DO/PA Fax #: (____) ____-____
Date:____/____/____

Notes

☐ Dictation to Follow (If dictations to follow please send to the attention of Shauna Smith)
☐ Dictation Attached
☐ Office Notes ☐ MRI Report ☐ Order (Rx) ☐ Demographics
☐ Insurance ☐ Other:_____

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