PRECISION PAIN MEDICAL

- 6500 Boeing Dr L190
- El Paso Tx 79925 -Principal Office
- Phone 877.679.1819
- EMAIL: info@precisionpainmed.com
- www.PrecisionPainMed.com

INTERVENTIONAL PAIN MANAGEMENT REFERRAL

Patient Name: _____ Date: _____

Patient Address: _____

Patient Phone: _____ Patient DOB: _____

Insurance: _____ Policy Number: _____

Date of Incident: _____ Attorney: _____

Referring Physician: _____ Physician Ph:_____

Physician Fax: _____

Reason for Referral:

_____ Evaluate & Treat _____ Initial Medical Consult (MD Consult) _____Orthopedic Consult

Conditions:

___ Neck Pain ___Mid Back Pain ___Low Back Pain ___Joint/Extremity Pain

If you request selective intervention for this patient, please indicate below:

____ Facet Injection ____ Epidural Steroid Injection ___ Sacroiliac Joint Injection

Comments: _____

_____

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