PREMIER PAIN & SPINE

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Patient:____ DOB:____________________

Date:________________ Cell#:___________________Home#:___________________

Chief Complaint/Diagnosis:____

☐ PAIN EVALUATION & CONSULTATION

PLEASE FAX COPIES OF ANY DIAGNOSTIC REPORTS (MRI, CT, X-RAY, ETC.), AS WELL AS THE MOST RECENT PHYSICIAN'S NOTES RELATED TO THE PATIENT ALONG WITH THIS REQUEST FORM

- ☐ Botox Treatment for Migraines and Cervical Dystonia
- ☐ Celiac Plexus Block
- ☐ Diagnostic Nerve Block
- ☐ Discography
  ___cervical ___thoracic ___lumbar
- ☐ Epidural Steroid Injection
  ___cervical ___thoracic ___lumbar
- ☐ Facet Joint Injection
  ___cervical ___thoracic ___lumbar
- ☐ Facet Rhizotomy/RF Ablation
- ☐ Hip Steroid Injection
- ☐ Intercostal Nerve Block
- ☐ Knee Steroid/Hyaluronan Injection
- ☐ Kyphoplasty
- ☐ Lumbar Sympathetic Block
- ☐ Occipital Nerve Block
- ☐ Selective Nerve Root Block
  ___cervical ___thoracic ___lumbar
- ☐ SI Joint Injection
- ☐ Spinal Cord/Transmuscular/Peripheral Stimulator Trial
- ☐ Stellate Ganglion Block
- ☐ Stem Cell/PRP
- ☐ Trigger Point Injection
  ___cervical ___thoracic ___lumbar

☐ **Level Desired (If applicable):** ________________________________

☐ Other: ____

Referring Physician:_________________________________ Phone: _______________

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