INTERVENTIONAL PAIN
CONSULTANTS

Please fax this Referral Form to: 618-465-7176

Date: _____ **Clinic Location: Alton or O'Fallon**

Referring Provider: _____ Referring Provider NPI: _____

Referring Provider phone: _____ Referring Provider Fax:_____

Patient Name: _____

Patient DOB: _____

Patient Phone: _____

Patient Address: _____

Patient Insurance: _____

Check All That Apply:

O Evaluate/treat as you deem appropriate O Kyphoplasty Consult

O Medication Management O Taking over medication management: Yes or No

O Special Request _____

Request A Procedure:

O Epidural Injection Series O Facet Injections/Medical Branch Block O Radio Frequency Ablation O SI Joint Injections O Trigger Point Injections O Joint Injections O Bursa Injections O Transforaminal Epidural O Selective Nerve Root Block O Spinal Cord Stimulator Trial O Occipital Nerve Block O Sympathetic Nerve Blocks O Pain Pump O Dorsal Root Ganglion Stimulation O Other: _____

Submit the Following Documentation With Referral:

O Demographic Sheet O Recent Imaging O Last Office Visit O Copy of Insurance card or Workman's Comp Information O Insurance referral if required

Referring Provider Signature: _____ Date: _____

Thank you for your referral to Interventional Pain Consultants, IPC.
We appreciate your support and trusting us with your patients.