



REFERRAL TO INTERVENTIONAL PAIN MANAGEMENT

Please fax this completed form to 832.436.4050 or email to referrals@houstonpainandspine.com

REFERRING PHYSICIAN

Physician Name: _____ Practice Name: _____

Date: _____ Phone: _____ Fax: _____

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____ Date
of Birth: _____ Phone: _____

Insurance Information: _____

SERVICES

- Consultation only
- Referral with ongoing management
- Consultation with procedure as appropriate
- Procedures only (please indicate procedure from the list below)

PROCEDURE ONLY

- Epidural steroid Level: _____
- Transforaminal epidural
Level side: R _____ L _____
- Facet joint injection
Level side: R _____ L _____
- Trigger point injection
area: _____
- Discogram
area: _____
- Spinal Cord Stimulator
- Evaluation for Intrathecal Drug Delivery
- Other (please specify)

DIAGNOSIS

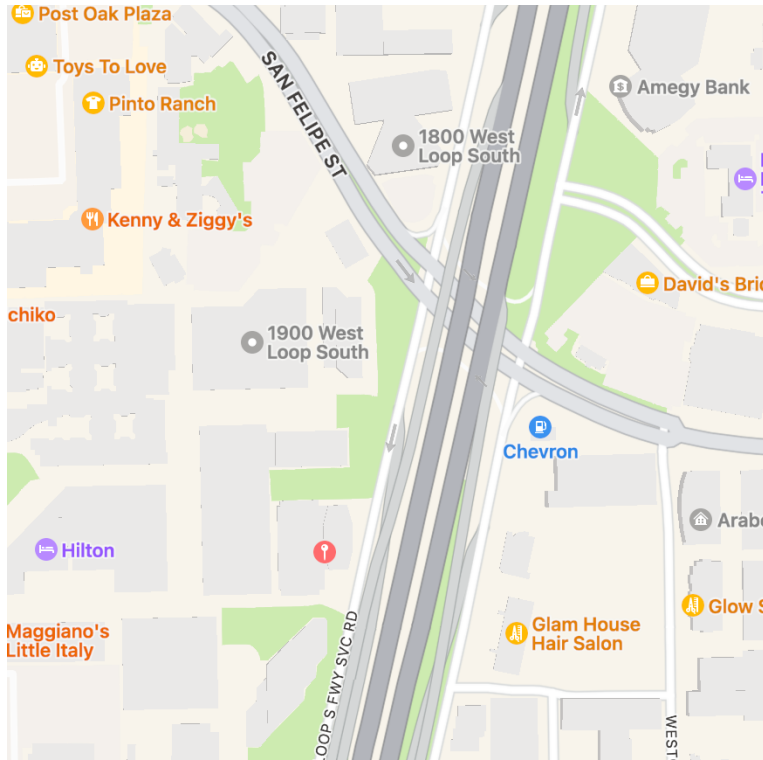
- Chronic back and leg pain
- Failed back surgery syndrome
- Complex regional pain syndrome
- Regional sympathetic dystrophy
- Radiculopathy
- Malignant pain
- Arachnoiditis
- Neuralgia
- other _____

FOLLOW UP CARE

- I would like to see this patient for a follow-up appointment after the procedure.
- I am referring this patient to you for long-term care.

OFFICE NOTES

LOCATIONS



HOUSTON OFFICE

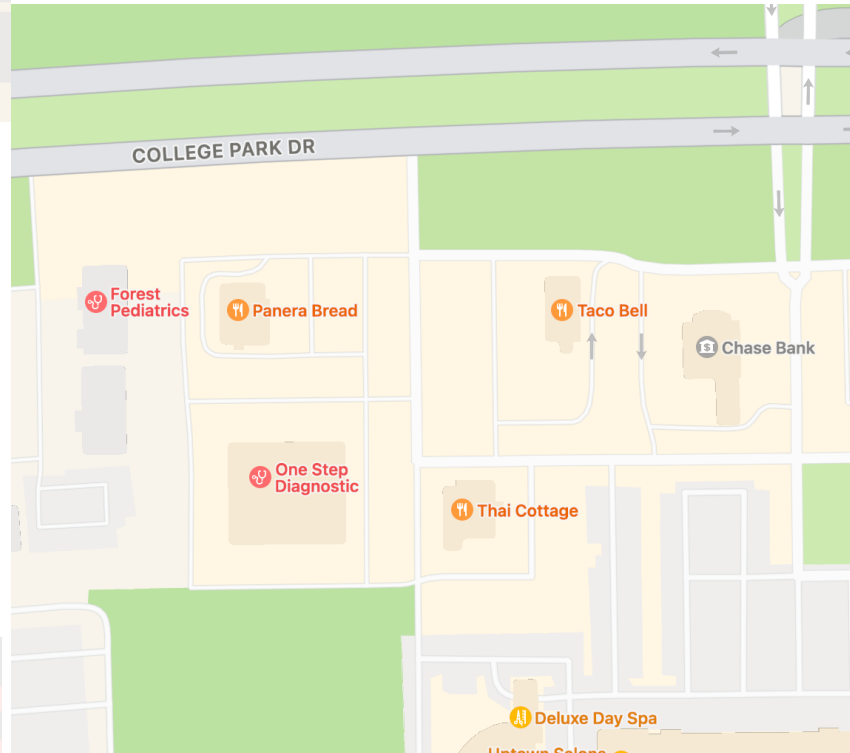
2100 WEST LOOP SOUTH SUITE 400
HOUSTON, TX 77027

FREE PARKING IS AVAILABLE ON ALL FLOORS OF
THE GARAGE

WOODLANDS OFFICE

3117 COLLEGE PARK DRIVE SUITE 210
THE WOODLANDS, TX 77384

FREE PARKING IS AVAILABLE ON THE SURFACE
LOT



KINGWOOD OFFICE

215 KINGWOOD EXECUTIVE DRIVE SUITE 100
KINGWOOD, TX 77384

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