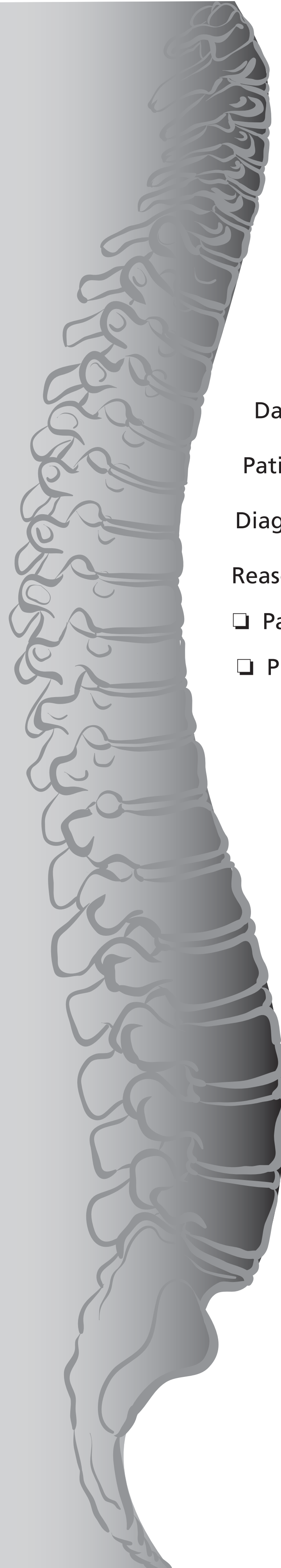

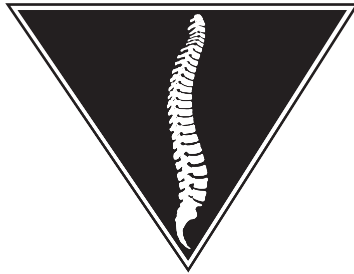

Interventional Pain Management

Louis M. Panlilio, MD
Theodore S. Grabow, MD
Brian M. Block, MD, PhD
Mary Ann Anthony, MSN, CRNP
Jennifer Keefer, MSPS, PA-C

Date: ____

Patient's Name: ____________________________________

Diagnosis: ____

Reason for Request:

❑ Pain Consultation: ____

❑ Procedure: (include levels if applicable)

❑ Epidural Steroid Injection ____________ ❑ Discography ________________

❑ Facet Injection ____________________ ❑ Major Jt/Bursa Inj ____________

❑ Implantable Technologies ____________ ❑ Nerve Root Block ____________

❑ Other (specify) ____

***To expedite patient scheduling, please fax the following:

❑ This completed referral form

❑ Patient detail sheet

❑ Office notes that pertain to the patient's diagnosis (last one or two notes)

❑ Diagnostic reports: written MRI, CT scan, x-ray reports

Comments: ____

____

Signature: _________________________________

Print Name: ________________________________

Office Phone: ______________________ Office Fax: ______________________

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