



# Interventional Pain Management

## FAX-A-CONSULT

PHONE: (478) 474 -AXIS (2947)

FAX: (478) 971-4004

DATE: \_\_\_\_\_

Choose location:    Macon, GA    Warner Robins, GA    Dublin, GA

Patient Name: \_\_\_\_\_ Contact #: \_\_\_\_\_

Patient DOB: \_\_\_\_\_ Contact Fax #: \_\_\_\_\_

Referring MD: \_\_\_\_\_ Contact Email: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Primary Care MD: \_\_\_\_\_

### Please select reason for referral:

- ☐ Injection Therapy
- ☐ Spinal Cord Stimulator Trial
- ☐ Pain Medication Management
- ☐ Other: \_\_\_\_\_

### For Injection Therapy, please specify below:

(circle one from each line):

Cervical	Thoracic	Lumbar
Facet	Epidural	Transforaminal

### Please fax the following information:

- ☐ Patient Demographics
- ☐ Insurance Card (front & back)
- ☐ Patient's last 3 office notes
- ☐ Imaging pertaining to referral
- ☐ UDS results (if available)

Tricare or VA Patients: Referring provider must submit for Tricare/VA referral. Please list referral # below

- ☐ Referral # \_\_\_\_\_

### If patient has been to pain center in past, will need this additional information prior to scheduling:

- ☐ Last 6 office notes
- ☐ Last 3 UDS results
- ☐ Discharge letter (if available)