# Valley Pain Clinic

**2208 Danville Road SW – Suite G**
**Decatur, AL. 35601**
**Phone: (256) 301-9994 Fax: (256) 301-5545**

## Referral Form

### Interventional Pain Management

***Referring Physician:***

Physician Name: _____ Practice Name: _____

Date: _____ Phone: _____ Fax: _____

***Patient Information:***

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____ Phone: _____

Insurance: _____ Member ID/Policy Number: _____

## Services

[ ] Consultation Only

[ ] Evaluate and Treat

[ ] Consultation with procedure as appropriate

[ ] Procedures Only

[ ] Discogram

[ ] Epidural Steroid Level: _____

[ ] Transforaminal Epidural

Level Side: R: _____ L: _____

[ ] Facet joint injection

Level Side: R: _____ L: _____

[ ] Trigger point injection

Area: _____

[ ] Neurostimulation

[ ] Others (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 app. after the procedure

[ ] I'm referring this patient to you for long term care.

Office Notes: _____

**Please fax this completed form along with 1-Patient's demographic / insurance information**
**2- Current medication list 3- most recent (last 3 visits) office notes, and any**
**4- diagnostic/ imaging reports To (256) 301-5545**