Interventional Pain Center

Office # 615-972-1100 | Fax # 615-537-4950

Hendersonville Medical Center location
353 New Shackle Island Rd Suite 101-A
Hendersonville, TN 37075

Skyline Medical Center location
3443 Dickerson Pike Suite 730
Nashville, TN 37207

REFERRAL FORM				
Date:_____		Patient Name:_____		
Referring Provider:_____		Patient DOB:_____		
Referring Provider Phone:_____		Referral Diagnosis:_____		
Referring Provider Fax:_____		Referring NPI #:_____		
REASON FOR REFERRAL				
☐ Evaluate/treat for pain management				
☐ Procedure Only				
☐ Special Request:_____				
REQUESTING PROCEDURE				
☐ EPIDURAL INJECTION SERIES	___Cervical	___Thoracic	___Lumbar	
☐ FACET INJECTIONS/MEDIAL BRANCH BLOCK	___Cervical	___Thoracic	___Lumbar	
☐ RADIO FREQUENCY ABLATION	___Cervical	___Thoracic	___Lumbar	___Sacroilliac
☐ DISCOGRAM	___Lumbar			
☐ JOINT INJECTION	___Shoulder	___Hip	___Knee	
☐ SPINAL CORD STIMULATOR TRIAL				
☐ TRIGGER POINT INJECTION				
☐ REGENERATIVE THERAPY (STEMS CELLS, PROLOTHERAPY, PRP - PLATELET-RICH PLASMA)				
☐ SI JOINT INJECTION				
☐ ULTRASOUND GUIDED INJECTION				
☐ OTHER_____				

PLEASE SUBMIT THE FOLLOWING DOCUMENTATION WITH REFERRAL:

1. DEMOGRAPHICS SHEET
2. COPY OF INSURANCE CARD OR WORKER'S COMP INFORMATION
3. MOST RECENT OFFICE NOTES
4. MOST RECENT IMAGING REPORTS

Please Fax referral documents to **Fax#: (615) 537-4950**

We will call the patient, schedule the appointment and then fax that information back to you.

STAFF USE ONLY

Patient Notified_____ Appointment Date/Time_____