Interventional Pain Center, PLLC

www.ipcpaincenter.com
Phone: 615-972-1100
Fax: 615-537-4950

REFERRAL FORM	
Date:_____	Patient Name:_____
Referring Provider:_____	Patient DOB:_____
Referring Provider Phone:_____	Referral Diagnosis:_____
Referring Provider Fax:_____	Referring NPI #:_____

COMPLETE AUTHORIZATION FORM
☐ Evaluate/treat for pain management
☐ Procedure Only
☐ EMG/NCS 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				
☐ VERTEBROPLASTY/KYPHOPLASTY				
☐ 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_____