Center *for* Pain Management

Interventional Treatment
For Acute, Chronic & Cancer Pain

Center *for* Pain Management

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www.centerforpainmanagement.org

TREATMENT ORDERING FORM

Please Provide Patient Information (Please attach a copy of the patient demographics and/or insurance card.)

PATIENT NAME: _____ **DOB:** _____/_____/_____

Address: _____

City: _____ State: _____ Zip: _____

Ph#: _____ Cell#: _____

INSURANCE: _____

DIAGNOSIS: _____

TREATMENT ORDER

- ❑ **Epidural Steroid Injection (Interlaminar): _____Lumbar _____ Cervical _____Thoracic**
  - **Level/s** _____
- ❑ **Transforaminal Epidural Steroid Injection: _____Lumbar _____ Cervical _____Thoracic**
  - **Side:** _____Right _____Left _____Bilateral **Level/s**:_____
- ❑ **Nerve Root Injection: _____ Lumbar _____ Cervical_____ Other:**
  - _____ **Therapeutic** _____ **Diagnostic**
  - **Side:** _____Right _____Left _____Bilateral **Level/s** :_____
- ❑ **Facet Joint Injection: _____ Lumbar _____ Cervical_____ Other:**
  - **Side:** _____Right _____Left _____Bilateral **Level/s**: _____
- ❑ **SI Joint Injection:**
  - **Side:** _____Right _____Left _____Bilateral
- ❑ **Lumbar Discogram:** _____ **Level/s:**_____
- ❑ **Hardware Injection:** _____ **Level/s:**_____
- ❑ **Trigger Point Injection:** _____
- ❑ **Other:** _____
- ❑ **Evaluate and Treat:** _____

Date _____ **Ordering Provider Signature** _____

Follow-Up Appointment set: _____