

# Fast Track Injection Referral Form

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

# of pages faxed \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

**URGENT** (< 7 days)  **SEMI-URGENT** (1-2 week)  **ELECTIVE** (next available opening)

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Phone number(s): \_\_\_\_\_

Symptoms: \_\_\_\_\_ Dx/ICD-9: \_\_\_\_\_

## **Injection Requested:**

_____ Epidural Steroid Injection:	Level(s): _____	
_____ Facet Injection	Level(s): _____	
_____ Selective Nerve Root injection	Level(s): _____	Right/Left
_____ Medial Branch Nerve Injection:	Level(s): _____	Right/Left
_____ Joint Injection:	Sacroiliac/Other: _____	Right/Left
_____ Bursa Injection:	Trochanteric/Ischial/Other: _____	Right/Left
_____ Stellate Ganglion Block		
_____ Radiofrequency	Level(s): _____	Right/Left
_____ Intrathecal Pump Evaluation		
_____ Dorsal Column Stimulator Evaluation		
_____ Other: _____		

Insurance: Primary: \_\_\_\_\_ (photocopy)

Secondary: \_\_\_\_\_ (photocopy)

## **Please include the following information:**

Patient demographics

Reports from latest: MRI/CT/XRAYS

Latest clinic notes

Pertinent labs

Copy of insurance cards

List of current medications