CENTER FOR
PAIN MANAGEMENT
AT ISLAND HOSPITAL

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REFERRAL FORM

Patient Name:______________________________ Phone:______________________

Insurance:______________________ Subscriber #:______________ DOB:__________

Diagnosis:____

DESCRIPTION OF SERVICES:	LEVEL:	SIDE:
Epidural/Interlaminer Steroid Injection		
❑ Cervical/Thoracic ESI (62321)	________	
❑ Lumbar ESI (62323)	________	
Facet Joint Injection/Medial Branch Block		
❑ Cervical/Thoracic ESI (64490)	________	R L BIL
❑ Lumbar ESI (64493)	________	R L BIL
Selective/Transforaminal Nerve Root Block		
❑ Cervical/Thoracic ESI (64479)	________	R L BIL
❑ Lumbar (64483)	________	R L BIL
❑ SI Joint Injection (27096)	________	R L BIL
Rhizotomy/Neurotomy		
❑ Lumbar (64635)	________	R L BIL
Ultrasound-Guided Procedures		
❑ Ultrasound-guided Injections/Dx – hip, shoulder, knee, wrist	________	R L BIL

24 HOURS CANCELLATION NOTICE REQUIRED

PRE-PROCEDURE INSTRUCTIONS:

1. If you request sedation, you will need to have someone drive you home.
2. No food or beverages 2 hours prior to your appointment.
3. Do not take any pain medications the day of your procedure. All other medications may be taken with sips of water.
4. All blood thinning medications (ie. Coumadin and Plavix) need to be held 7 days prior to your injection. NOTIFY your prescribing doctor that you need to hold this medication and follow their instructions.

Referring Physician:______________________________ Phone:______________________

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