Advanced Interventional PAIN Management

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Reason for Referral:

- ❑ Neck Pain
- ❑ Back Pain
- ❑ Shoulder Pain
- ❑ Knee Pain
- ❑ Hip Pain
- ❑ Acute/Chronic Radiculopathy
- ❑ Peripheral Neuropathy
- ❑ Shingles Pain
- ❑ Cervicogenic Headaches

- ❑ Epidural Steriod Injection | Location:_____
- ❑ Radiofrequency Ablation: Facet | SIJ | Genicular (knee)
- ❑ Spinal Cord Stimulation
- ❑ Other:_____
- ❑ Ketamine Infusion (Pain/Deression)
- ❑ Platelet Rich Plasma

Patient Name:_____ DOB:_____

Patient Phone #:_____ Alternate Phone #:_____

Patient Home Address:_____

City:_____ State:_____ Zip Code:_____

Please send copy of Insurance Card (front & back)

Insurance Company:_____ Phone #:_____

ID #:_____

Referring Provider:_____

Clinic Phone #:_____ Clinic Fax #:_____

GetPainFree.com ✆ **501-624-7246**

[Please fax referrals to 501-321-2945]

Please include the last clinic note and any relevant imaging of the painful area.
A medicaid referral is required for all medicaid patients.