EVALUATION and/or PROCEDURE REQUEST

Interventional Pain Management Center

☐ Burlington Office Number: 781-744-5090 Fax Number: 781-744-5624
☐ Peabody Office Number: 978-538-4575 Fax Number: 978-538-4048

Patient Name:_____ Referring Provider:_____

Home Phone:_____ Office Phone:_____

Address:_____ Date:_____

_____ Insurance:_____

Policy #:_____

***Diagnosis:** _____

_____ Lahey # (if applicable)_____

_____

* All patients will undergo thorough diagnostic evaluation prior to any procedures. Procedures to be done only as indicated for diagnostic/therapeutic benefit. Please send/fax recent evaluations/ results with this form as appropriate.

PROCEDURE REQUESTED (If known, check all that apply)
(L=Left, R=Right, B=Bilateral)

I. Spine

A) Epidural steroids at level:_____

B) Facet Joint blocks (median branch nerve, cervical/thoracic/lumbar)
At levels:_____ R_____ L_____ B_____ RF ablation_____
(Standard to do L3-4,L4-5,L5-S1 bilateral for generalized "low back pain")

C) Discograms
Suspected disk (will do adjacent controls also):_____

D) Nerve Root Blocks at neuroforamina
Levels:_____ R_____ L_____ B_____

E) Transforaminal Epidural Steroids at level:_____

F) Trial intrathecal opiate:_____(for continuous infusion external/internal systems)(Baclofen_____(for spasticity))

G) Trial spinal cord stimulation:_____

H) Other "spine" not listed:_____

To Complete Please Turn to Next Page

II. Sympathetic Plexus/nerves

A) Lumbar sympathetic:_____ R:_____ L:_____ (lower extremity "RSD")
B) Celiac plexus:_____Alcohol?_____(abdominal pain)
C) Stellate ganglion:_____ R:_____ L:_____ (upper extremity "RSD")
D) Sup. Hypogastric plexus:_____ (pelvic/perineal pain)

III. Peripheral Nerves

A) Intercostal nerve(s):_____ R:_____ L:_____
B) Brachial Plexus:_____ R:_____ L:_____
C) Lumbar plexus:_____ R:_____ L:_____
D) Ilioinguinal nerve:_____ R:_____ L:_____
E) Genitofemoral nerve:_____ R:_____ L:_____
F) Lateral femoral cutaneous:_____ R:_____ L:_____
G) Femoral nerve:_____ R:_____ L:_____
H) Sciatic nerve:_____ R:_____ L:_____
I) Radial nerve:_____ R:_____ L:_____
J) Ulnar nerve:_____ R:_____ L:_____

K) Upper extremity, name of nerve(s):_____
R:_____ L:_____

L) Lower extremity, name of nerve(s):_____
R:_____ L:_____

M) Other nerves not listed:_____
R:_____ L:_____

IV. Myofascial Pain Syndrome

A) Trigger point injections:_____
Location(s):_____

B) Botox trigger point injections:_____
Location(s):_____

Unlisted procedure/block:

_____

_____

_____