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Flint Hills PAIN MANAGEMENT PA

PATIENT INFORMATION

Today's Date / / Patient Name: Gender: ☐ M ☐ F
Date Of Birth / / Daytime Phone: Evening Phone:
Insurance: Phone:
Workers' Compensation Auto Accident Carrier:
Pre-Authorization needed (Yes/No): Authorization #:
Via Appointment Date: / / Arrival Time: Notes:
Interpreter Needed – Language:

PROCEDURE / AREA OF PAIN

SPINE PAIN MANAGEMENT
- ☐ Epidural Steroid Injection
- ☐ Facet Steroid Injection
- ☐ Selective Nerve Root Block
- ☐ Sacroiliac Joint Steroid Injection
- ☐ IPM / Spine Injection Consultation
- ☐ Other :_____

LEVEL _____ L R

JOINT PAIN MANAGEMENT
(specify)_____
LEVEL _____ L R

PLEASE SPECIFY:
- ☐ Headache/Migraine
- ☐ TMJ / Facial Pain
- ☐ Neck Pain
- ☐ Shoulder Pain
- ☐ Arm Pain
- ☐ Wrist/Hand Pain
- ☐ Carpal Tunnel Syndrome
- ☐ Mid-Back Pain
- ☐ Rib Pain
- ☐ Low-Back Pain
- ☐ SI Joint Pain
- ☐ Sciatica
- ☐ Ankle/Foot Pain
- ☐ RSDS
- ☐ Hip Pain
- ☐ Leg Pain

PLEASE SPECIFY:
- ☐ Work Injury
- ☐ MVA Injury

Other_____
_____

DIAGNOSIS / HISTORY

Diagnosis and Area:
Symptoms and Duration:
Allergies:
Prior Exams and Locations:
Prior Injections (Include Doctor or Clinic):
Prior MRI (please send findings):

PRIMARY PHISICIAN INFORMATION

Referring Physician/Office:
Phone Number: Fax Number:
Report you wish to receive:
☐ Fax Report ☐ Telephone Report ☐ Copy of Additional Exam Findings (specify):

****Ordering physician signature:**

REFERRING OFFICE, PLEASE FAX THIS TO (785) 320-5428
with any imaging written reports

Thank you for referral!

Sorry, we **DO NOT** accept Medicaid Insurance & we will **NOT** provide prescription medication.