Valley Pain Center
Masons Mill Park II
1800 Byberry Road, Suite 1101
Huntingdon Valley, PA 19006
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www.ValleyPainCenter.com

Physician Referral Form

Name: ______________________ Date: ______________________

From Dr. ______________________ Phone: ______________________

Patient Information. Please fax patient demographics with this referral.

Option 1

☐ **Consult and Treat Patient as Needed**

Please check the treatment modalities you would like us to arrange for your patient as indicated:

Including:

☐ Interventional Pain Procedures ☐ Medication Management
☐ Diagnostics ☐ Physical Therapy

Option 2

☐ **Interventional Pain Management Only**

Please indicate the specific procedure(s) you are requesting:

☐ Epidural Steroid Injection
Circle one: Lumbar Cervical Thoracic

☐ Lumbar Selective Nerve Root Block
Levels: __________ Side: __________

☐ Sympathetic Nerve Block

☐ Epidural Blood Patch

☐ Caudal Epidural

☐ Other: ______________________

☐ Facet Block
Circle one: Lumbar Cervical Thoracic
Levels: __________ Side: __________

☐ SI Joint Injection
Circle one: Right Left Bi-Lateral

☐ Radio Frequency Lesioning
Circle one: Lumbar Cervical Thoracic SI
Levels: __________ Side: __________

Discogram: Levels: ______________________
Circle one: Lumbar Cervical Thoracic

Clinical Information ______________________

For requests, please send: All Diagnostic Test Reports Related to the reasons for referral, and most recent notes dealing with the patient's pain issue.