"Accurate Diagnosis and Targeted Treatment of Pain"

Referral Form

Fax to 865-305- 4025

Referral Date: ____________

PLEASE SUBMIT ☐ Demographics ☐ Recent Office Notes ☐ Relevant Imaging ☐ Insurance Cards

REQUESTED PHYSICIAN

☐ First Available ☐ Jason M. Buehler, MD ☐ Mark B. Murray, MD
☐ Jeffrey B. Staack, MD ☐ Mathew B. Vance, MD ☐ Stephanie G. Vanterpool, MD, MBA

PATIENT INFORMATION

Last Name ____ First Name: ____ DOB ____

Home Phone ____ Cell Phone ____ Email Address ____

Special Considerations – Patient being treated by the following:

☐ Blood Thinners ☐ Pacemaker/AICD ☐ Spinal Cord Stimulator ☐ Bladder Stimulator ☐ Other ____________

PAIN COMPLAINT

- ☐ Headache
- ☐ Back Pain
  - ☐ Thoracic
  - ☐ Lumbar
- ☐ Neck Pain
- ☐ Extremity Pain
- ☐ Failed Back Surgery Syndrome
- ☐ Myofascial Pain/Muscle Pain
- ☐ Abdominal Pain
- ☐ Radiculopathy (Level____________)
- ☐ Complex Regional Pain Syndrome
- ☐ Other ____________

PROCEDURE

- ☐ Epidural Steroid
- ☐ Transforaminal Epidural
- ☐ Facet Joint Injection
- ☐
- ☐ Intra-articular Steroid
- ☐ Occipital Nerve Block
- ☐ SI Joint Injection
- ☐ Knee
  - ☐ Diagnostic
  - ☐ RFA
- ☐ Trigger Point Injection
- ☐ Spinal Cord Stimulation
- ☐ Other ____________

INSURANCE INFORMAITON

PRIMARY INSURANCE	SECONDARY INSURANCE
Insurance Type ____________	Insurance Type ____________
Insurance Carrier ____________	Insurance Carrier ____________
Group # ____________	Group # ____________
ID # ____________	ID # ____________

REFERRAL TYPE

☐ **Interventional Referral** – Opioid therapy will **NOT** be considered as part of evaluation

☐ **Comprehensive Referral** – Opioid therapy **MAY** be considered as part of evaluation

Referring Provider ________________________________
Physician Name Phone No Fax No

FOLLOW-UP CARE

☐ I would like to continue to manage this patient after the procedure

☐ I am referring the patient to you for long-term management