Board Certified ◦ Fellowship Trained
Interventional Pain Specialists
DiagnosticPainCenter.com

DPC DIAGNOSTIC PAIN CENTER

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Request for Pain Management Consultation

Date: ___________________

Patient Name: ____ D.O.B.: ____________________

Contact Phone #: ____

Insurance: ____

☐ Major Insurance: ____

☐ Medicare ☐ Wellmed ☐ Letter of Protection ☐ None/Self-Pay

Chief Complaint / Diagnosis: ____

Referring Provider: ____

Office Phone #: ____ Fax #: ____________________

Referral Type: ☐ Consultation and Treatment OR ☐ Specific Request (check box below)

If specific request, please check box or notate below:

- ☐ Spinal Cord Stimulator (Trial / Implant)
- ☐ Peripheral Nerve Stimulator (Trial / Implant)
- ☐ Dorsal Root Ganglion (DRG) Stimulator (Trial / Implant)
- ☐ Epidural Steroid Injection(s) (Cervical/Thoracic/Lumbar)
- ☐ Facet / Medial Branch Blocks (Cervical/Thoracic/Lumbar)
- ☐ Stellate Ganglion Sympathetic Block
- ☐ Adhesiolysis
- ☐ Radiofrequency Ablation/Neurolysis
- ☐ Sacroiliac Joint Injection(s)
- ☐ Joint Injection(s)
- ☐ Ketamine Infusion
- ☐ Genicular Nerve Blocks / Radiofrequency Ablation
- ☐ Botox Injections for Migraines
- ☐ Kyphoplasty / Vertebroplasty
- ☐ Peripheral Nerve Block(s)
- ☐ Selective Nerve Root Block(s)
- ☐ Trigger Point Injection(s)
- ☐ Occipital Nerve Block(s)
- ☐ Lumbar Sympathetic Block
- ☐ Platelet Rich Plasma / Prolotherapy
- ☐ Vertiflex / Superion Procedure
- ☐ Medical Cannabis (note indication below)

Please note any further details, specific requests, joints, and/or levels: ____________________

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Please fax this form to 512-981-7246

Please include any pertinent records, reports, and demographics.

Thank you for referring to the Diagnostic Pain Center!

Want more options? Check out diagnosticpaincenter.com/referrals or scan here:

NORTH OFFICE
12176 N. Mopac Expy
Suite D
Austin, TX 78758

SOUTH OFFICE
2765 Bee Cave Rd
Suite 201
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CONTACT
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