REFERRAL FORM

Date: _____

OMEGA INTERVENTIONAL PAIN MANAGEMENT

6348 Lonas Spring Drive, Knoxville, TN 37909

Phone: (865) 337-5137 Fax: (888) 839-6922

www.omegapaindoctor.com

Patient: _____

(Last Name) (First Name) (DOB) (Phone #)

Referring Provider:_____

Clinic Address/ Phone/ Fax:_____

_____

Step 1) REFERRAL TYPE:

☐ **Medication Management only** - Pt **DOES NOT WANT** injections

☐ **Comprehensive Referral** (Pt **WANTS** Injections +/- opiate therapy)

☐ **Interventional Referral (FAST TRACK) -** (Injections only/ NO OPIATES)

Step 2) DIAGNOSIS or Procedure (please mark one or more)

☐ **Focal LBP** ☐ **Trigger Point Injection** ☐ **Sacroiliitis (SI joint injection)**

☐ **Lumbar Radiculopathy** ☐ **Spinal Cord Stimulator Trial** ☐ **Sciatica**

☐ **Focal Neck Pain** ☐ **Caudal Epidural** Steroid Inj ☐**Joint Steroid Injection** (which one?)_____

☐ **Cervical Radiculopathy** ☐ **Lumbar Sympathetic Block** (CRPS LE's) ☐ **Prolotherapy** (cash)

☐ **Platelet Rich Plasma (PRP)** (cash) ☐ **OTHER DX:**_____

Please FAX the following to (888) 839-6922: ☐ **IMAGING STUDY** of the affected area

☐**INSURANCE CARD** (both sides) ☐Last **PROGRESS NOTE** ☐**DEMOGRAPHICS FORM**

OFFICE USE ONLY:

Patient has an appt scheduled with us on _____ at _____

Patient has not been accepted into our practice due to: _____