CUMBERLAND PAIN ASSOCIATES

Patient Name _____ SS# _____

Diagnosis _____ Date_____ Spine Care Patient ☐ Yes ☐ No

Referring Physician _____ Phone_____ Fax_____

☐ Consultation

☐ Return patient for evaluation after pain management consultation.

☐ Procedure(s) Only

☐ Epidural: ☐ Cervical ☐ Thoracic ☐ Lumbar Level(s)_____

☐ Discogram: ☐ Cervical ☐ Thoracic ☐ Lumbar Level(s)_____

☐ Selective Nerve Root Block: ☐ Cervical ☐ Thoracic ☐ Lumbar Level(s)_____

☐ Sympathetic Block: ☐ Stellate ☐ Cervical ☐ Lumbar ☐ Superior hypogastric ☐ Other_____

☐ Facet/Medial Branch Block: ☐ Cervical ☐ Thoracic ☐ Lumbar Level(s)_____

☐ Peripheral Nerve Block: ☐ Occipital ☐ Intercostal ☐ Median Nerve ☐ Ulner Nerve ☐ Radial Nerve ☐ Sciatic Nerve ☐ Pyriformis Block ☐ Femoral Nerve ☐ Ankle/Foot Block ☐ Other _____

☐ Neurolytic Block: Specify_____

☐ Evaluation for Spinal Cord Stimulator

☐ Evaluation for Intrathecal pump

☐ Evaluation for Percutaneous Lumbar Decompression / Intradiscal Electrothermal Annuloplasty

☐ Other _____

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