RICHMOND SPINE Interventions & Pain Center

Specializing in Spinal Injection Techniques, Spinal Cord Stimulation & Kyphoplasty for Vertebral Compression Fractures

Self Referral Form

Today's Date: _____

Name: _____
First Name Middle Name Last Name

Date of Birth: _____

Gender:

- ❑ Male
- ❑ Female
- ❑ Other: _____

Email: _____

Address: _____ _____
Street Address Street Address Line 2

_____ _____ _____
City State/Province Postal/Zip Code

Home Phone Number: ____ - _____ Mobile Number: ____ - _____
Area Code Phone Number Area Code Phone Number

Best Time To Call: _____

By choosing "YES" you consent to receive SMS messages. Messages and Data rates may apply. Message frequency will vary. (This is for appointment reminders or patient portal registration ONLY. No Mobile information will be shared with third parties/affiliates for marketing/promotional purposes.)

- ❑ Yes
- ❑ No

Is your pain a result of an auto accident?

- ❑ Yes
- ❑ No

If yes, Please explain: _____

Is there an active legal case going on?

- ❑ Yes
- ❑ No

Is your pain a result of a work-related injury?

- ❑ Yes
- ❑ No

If yes, Please explain: _____

Is there an active worker's compensation case/claim going on?

- ❑ Yes
- ❑ No

Do you have health insurance coverage?

- ❑ Yes
  Primary Insurance Name: _____

  Primary Insurance Plan ID Number: _____
- ❑ No

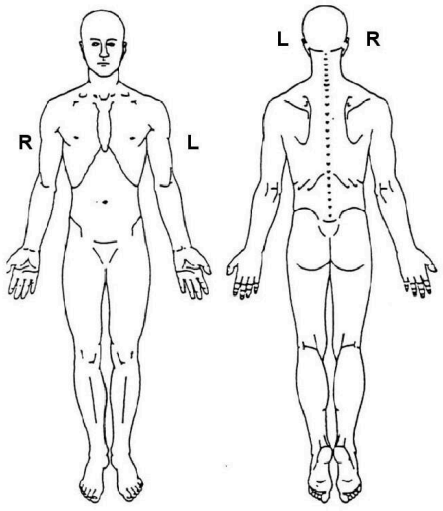
Medical Information

Please describe where your pain is located? (Ex. Lower back and radiate into my left leg.)

_____

_____

You may also help us visualize the location of your pain by shading the body part in the image provided below.



At our center, we primarily focus on the treatment of spine-related pain, hip, shoulder, knee, and some myofascial pain syndromes. We do not treat migraines or fibromyalgia-related pain at this time.

Are you seeking treatment primarily for migraine or fibromyalgia?

- ❑ Yes
- ❑ No

Please explain further if necessary: _____

Have you had a pain management physician in the past?

- ❑ Yes
- ❑ No

If YES, please explain the reasoning behind looking for another physician:

_____

_____

Have you taken any pain medications?

- ❑ Yes
- ❑ No

If YES, please list the medications you have taken with their dosage.

_____

_____

Have you had any spinal injections? (example: Epidural Steroid Injections, facet injections, etc)

- ❑ Yes
- ❑ No

If YES, Who was the performing provider? _____

When was the last injection date? _____
Approximate of exact date

What percentage of relief did you experience from your last injection?

__ 10% __ 20% __ 30% __ 40% __ 50% __ 60% __ 70% __ 80% __ 90% __ 100%

Have you had any of the following Imaging Studies? (attaching the report from your imaging studies may expedite your appointment)

- ❑ MRI
- ❑ CT Scan
- ❑ X- rays
- ❑ None
- ❑ Other: _____

If you have had imaging studies please list the study, approximate date it was performed and what facility it was performed at.

_____

Have you tried any of the following, in the past 2 years, for this condition/pain?

- ❑ NSAIDs
- ❑ Physical Therapy
- ❑ Chiropractor
- ❑ Pain Medication / Opioids ? Narcotics
- ❑ None of the Above

Any history of alcohol or substance abuse?

- ❑ Yes
- ❑ No

Who was your last pain management physician? _____

Have you ever been discharged from a doctor's practice?

- ❑ Yes
- ❑ No

Can we check your prescription monitoring program report?

- ❑ Yes
- ❑ No

Please Initial: _____

How is your name listed at your pharmacy? _____
Nickname, Full Name, etc

What kind of treatment are you looking for/expecting?

- ❑ Injections
- ❑ Medication Management
- ❑ Other _____

How did you hear about our practice?

- ❑ Primary care physician/provider : _____
- ❑ Specialist physician/provider : _____
- ❑ Hospital
- ❑ Internet search (google, yahoo, facebook etc)
- ❑ Friends and Family
- ❑ Insurance company
- ❑ Other _____

Full Name: _____
First Name Middle Name Last Name

Date: _____

Please be advised that incomplete forms will not be processed. Thank you!

For more information about our practice and our services, please visit:
www.RichmondSpinePain.com