Dartmouth-Hitchcock
MEDICAL CENTER

Phone: (603) 650-6040
Fax: (603) 650-8199

Procedure-Only Appointment Request

Pain Management Center

Patient must have a designated driver or procedure cannot be performed.

Patient name: _____ MRN: _____ Date: _____

Home phone: _____ Work phone:_____ Cell phone: _____

Mailing address: _____

Insurance: _____ DOB: _____ SSN: _____

Is this a Worker's Compensation claim? ❒ No ❒ Yes Date of injury: _____

Worker's Compensation contact: _____ WC contact's phone: _____

Are you requesting a specific provider? ❒ No ❒ Yes (specify) _____

Required Information – please complete the sections below.

Diagnosis: _____ Height: _____ Weight: _____

Is the patient currently taking antibiotics? ❑ No ❑ Yes (specify) _____

Medication: Metformin ❑ No ❑ Yes

Prior Spine Surgeries: ❑ No ❑ Yes (specify) _____

Anticoagulants: ❑ None ❑ Coumadin ❑ Plavix ❑ Fragmin ❑ Lovenox ❑ Other (specify) _____

Steroid Allergy: ❑ No ❑ Depo-Medrol ❑ Prednisone ❑ Celestone ❑ Solu-Medrol ❑ Other (specify) _____

Anesthetic Allergy: ❑ No ❑ Lidocaine ❑ Novacaine ❑ Bupivacaine ❑ Other (specify) _____

MRI/CT (date & area of body): _____

❑ **Please check box if you believe additional time may be required for this procedure due to:**

❑ Age > 90 years ❑ Morbid obesity ❑ Wheelchair ❑ Other _____

❑ IV sedation needed ❑ Language translator needed ❑ Spinal instrumentation

Please indicate procedure to be scheduled below:

❑ Lumbar Epidural Steroid Injection # _____ & frequency _____

❑ Caudal Epidural Steroid Injection

❑ Cervical Epidural Steroid Injection # _____ & frequency _____

❑ Thoracic Epidural Steroid Injection

❑ Transforaminal Injection ❑ Right ❑ Left ❑ Level(s) _____

MRI/CT REQUIRED FOR ALL OF THE ABOVE INJECTIONS

❑ Select. Nerve Root Block ❑ Thoracic ❑ Lumbar ❑ Sacral

❑ Right ❑ Left ❑ Level(s) _____

❑ SI Joint Injection ❑ Right ❑ Left

❑ Trigger Point Injection (Piriformis)

❑ Other: _____

❑ Ultrasound (subject to Pain Physician approval)

❑ Occipital Nerve Block ❑ Right ❑ Left

❑ Stellate Ganglion Block

❑ Lumbar Med. Branch/Facet Block ❑ Right ❑ Left ❑ Level(s)_____

❑ Cervical Medial Branch Block ❑ Right ❑ Left

*****C3 and below only*****

❑ Thoracic Medial Branch Block ❑ Right ❑ Left

❑ Lumbar Sympathetic Block ❑ Right ❑ Left

❑ Radiofrequency ❑ Cervical ❑ Thoracic ❑ Lumbar/Sacral ❑ SI Joint

❑ Right ❑ Left

*****Radiofrequency scheduled AFTER a successful block has been performed at the DHMC Pain Clinic*****

If patient information including medications, x-rays, physical exam, symptoms, and allergies is in CIS, skip section A and proceed to section B.

A. Pertinent symptoms: _____

Pertinent past medical history: _____

Pertinent PE findings: _____

MRI/CT/Myelogram results: _____

If scheduled: Test: _____ Date scheduled: _____ Facility: _____

Allergies/adverse drug reactions: _____

B. Referring provider: _____ Office #: _____

Contact person: _____ Fax #: _____

Please notify us of the appointment: ❑ No ❑ Yes

C. Patient follow-up instructions: Follow up with Referring Provider in _____ week(s) post _____ number of injections.