COFFEE REGIONAL
MEDICAL CENTER

INTERVENTIONAL PAIN PROCEDURE REFERRAL FORM

Phone: (912) 384–1900 ext 6918 FAX: (912) 389–2165

NOTE: Please send last office note and most recent CT or MRI of spine (if available). Cervical procedures will REQUIRE cervical spine MRI. Send complete order with diagnosis, procedure, date/time and physician.

REFERRING PHYSICIAN INFORMATION

Referring Physician: ______________________ Person Completing Form: ______________________

Phone #: ______________________ Fax #: ______________________

PROCEDURE INFORMATION (Please be SPECIFIC as to SIDE and Level of procedure)

Procedure Requested
CPT Code ______________________

Diagnosis ______________________ ICD10 ______________________

PATIENT INFORMATION

Patient Name: ______________________

Social Security #: ______________________ DOB: ______________________

Home Phone #: ______________________ Cell #: ______________________

Other Phone #: ______________________

Is patient taking warfarin (Coumadin), Plavix (clopidogrel), apixaban? (Eliquis), dabigatran (Pradaxa), rivaroxaban (Xarelto) or other anticoagulant? ❑ Yes ❑ No

Is patient allergic to contrast dye, IVP dye, shellfish or iodine? ❑ Yes ❑ No

Is there ANY possibility that the patient is pregnant? ❑ Yes ❑ No

INSURANCE INFORMATION

Insurance Co Name: ______________________ Policy #: ______________________

Pre–cert #: ______________________ No pre–cert needed per: ______________________

Workman's comp approved per: ______________________ Phone #: ______________________

APPOINTMENT INFORMATION

Appointment date: ______________________ @ ______________________ A.M. / P.M.

Patient notified on: ______________________ by ______________________

Physician Signature: ______________________ Date/Time ______________________