RIVER CITIES
INTERVENTIONAL
PAIN SPECIALISTS

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Diagnostic Injection Service (DIS)

☐ DIS w/ follow-up by referring MD
☐ DIS w/ Pain Management consult after DIS and ongoing follow-up
☐ DIS w/Pain Management consult before DIS and ongoing follow-up

Today's Date: _____
Referring MD:_____
Contact Person:_____ Phone:_____
Procedures Requested (include Right/Left/Bilateral if appropriate):

☐ Selective Nerve Root Block-- Lumbar Sacral, Level(s): _____

☐ Epidural Steroid Injection-- Cervical Lumbar Caudal, Level(s): _____

☐ Facet Joint Injection/MBB/RF-- Cervical Lumbosacral, Level(s):_____

☐ Intra-Articular Joint Injection fluoro/ultrasound-- Hip Knee Other_____

☐ Other Injection: _____

Referring Diagnosis:_____

Patient Information:

Name:_____

Address:_____
Home Phone:_____Alternative Contact Number:_____
Primary Insurance:_____Secondary Insurance:_____

ANTICOAGULATION: ☐ No ☐ Yes (If Yes, Medication:_____ and Prescribing MD_____)

We will contact your patient within 48 hours of receiving your fax and supporting documents. Please attach applicable imaging.We will make every effort to see our patient within 1 week. If you have any questions, please contact the Practice Manager,Camille Weeks at cweeks@rivercities.net or 318-797-5848.