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Consult/Procedure Request Form

Patient Name: _____ Date:_____

Requesting Provider: _____ Phone: _____ Fax: _____

Diagnosis / History: _____

Prior Surgery: _____ Pathology / Imaging: _____

☐ Consultation / Treatment: Provider Requested:

☐ WC / MVA: ☐ Electrodiagnostic (EMG) Consult:

☐ Spine Interventions; Diagnostic/Therapeutic Injections: _____

☐ Epidural Steroid Injection: Interlaminar: _____ Transforaminal: L R B Levels: _____

☐ Selective Nerve Root Block: L R B Level: _____ ☐ With Corticosteroid

☐ Discography: _____ Post Disco CT (yes/no)

☐ Facet (Zygapophysial) Joint Injection(s): L R B Level: _____

☐ Medial Branch Block: L R B _____RF Neurotomy: _____

☐ Sacroiliac Joint: L R B ☐ Piriformis L R B ☐ Hip L R B ☐ Pars Interarticularis

☐ Fusion Hardware: L R B ☐ C0-1 L R B ☐ C1-2 L R B ☐ Sympathetic (Lumbar/Cervical) L R

☐ Details/Staging/Other: _____

☐ Spinal Cord Stimulation ☐ Regenerative Medicine _____

This consult/procedure request constitutes a letter of medical necessity.

Signature:_____ Date: _____