FAST TRACK INJECTION FORM

Date:_____ **# of pages faxed**_____

Referring physician:_____ **Contact:**_____ **Phone:**_____

☐ URGENT (<7 DAYS) ☐ SEMI URGENT (1-2 WEEKS) ☐ ELECTIVE (next available opening)

Primary Care Physician_____ **Phone**_____

Patient Name_____ **Phone number(s):**_____

Symptoms:_____ **Dx/ ICD-9 code**_____

Injection Requested:

_____**Epidural Steroid Injection** **Level(s):**_____

_____**Facet Joint Injection** **Level(s):**_____ **Right/Left**

_____**Selective Nerve Root Injection** **Level(s):**_____ **Right/Left**

_____**Medial Branch Nerve Injection** **Level(s):**_____ **Right/Left**

_____**Joint injection** **Sacroiliac/Other**_____ **Right/Left**

_____**Bursa Injection** **Trochanteric/Ischial/Other**_____ **Right/Left**

_____**Radiofrequency** **Level(s):**_____ **Right/Left**

_____**Stellate Ganglion Block**

_____**Intrathecal Pump Evaluation**

_____**Dorsal Column Stimulator Evaluation**

_____**Other:**_____

Insurance: **Primary**_____**(photocopy)**

Secondary_____**(photocopy)**

Please include the following information:

Patient demographics **Reports from latest MRI/CT/XRAYS** **Latest Clinic Notes**
Pertinent Labs **Copy of insurance cards** **List of current medications**