RichmondSpine
INTERVENTIONS & PAIN CENTER

Self-Referral Sheet

Today's Date: _____

Name: _____ DOB: _____/_____/_____

Address: _____

_____

Phone Number: _____ Best time to call: _____

Primary Insurance: _____ Secondary Insurance:_____

Where is your pain located? _____

_____

Are you bring treated for: ☐ Migraines ☐ Fibromyalgia , If yes to any of these, which provider is currently managing this condition? _____

Have you taken any pain medications? (Please List) ☐ Yes ☐ No

_____

Have you had any spinal injections (ex. Epidural steroid injections, facet injections)?

☐ Yes ☐ No Performing Doctor: _____ Last Injection Date: _____

Percentage of Relief: ☐10% ☐20% ☐30% ☐40% ☐50% ☐60% ☐70% ☐80% ☐90% ☐100%

Have you had any of the following imaging studies for this condition/pain? *(attaching the report from your imaging studies may expedite the appointment)*

☐ MRI (Date and location performed): _____

☐ CT Scan (Date and location performed): _____

☐ X-rays (Date and location performed): _____

Have you tried any of the following within the past 2 years for this condition/pain?

☐ NSAIDS ☐ Physical Therapy ☐ Chiropractor ☐ Pain Medication/Opioids/Narcotics

Any history of alcohol or substance abuse: ☐ Yes ☐ No

Who was your last Pain Management Doctor? _____

If you have one, why are you no longer seeing that physician/changing your care to our office?

_____

Have you ever been discharged from any doctor's practice? ☐ Yes ☐ No

Can we check your Prescription Monitoring Program Report? ☐ Yes ☐ No

How is your name listed at your Pharmacy? (Nickname, full name, etc) _____

What kind of treatment are you looking for/expecting? ☐ Injections ☐ Medication Management

☐ Other: _____

Referred by: _____ Phone: _____

Please be advised that Incomplete forms will not be processed. Thank you!

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