VALLEY
PAIN CONSULTANTS

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F: 480.970.1448

☐ ***Shea***
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Scottsdale, AZ 85258
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☐ ***North Scottsdale***
5425 East Bell Rd, Suite 115
Scottsdale, AZ 85254
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☐ ***Thompson Peak***
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☐ ***Central Phoenix***
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☐ ***West Valley***
6780 W. Thunderbird Rd, Suite A105
Peoria, AZ 85381
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☐ ***Estrella***
9305 W. Thomas Rd, Suite 500
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☐ ***Chandler***
2095 W. Pecos Road, Suite A8
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William C. Thompson IV, MD
Monica Torres, MD

NEW PATIENT REFERRAL

Date: _____

Patient Name: _____ DOB: _____

Home #: _____ Work #: _____ Cell #: _____

Referring Physician Name: _____

Referring Physician Phone #: _____ Fax #: _____

Chief Complaint/Diagnosis: _____

Insurance Carrier: _____

Authorization #: _____ Expiration Date: _____

☐ Pain Consultation and Treatment
☐ Epidural Steroid Injection
__ Cervical __ Thoracic __ Lumbar
☐ Facet Joint Injection
__ Cervical __ Thoracic __Lumbar
☐ Selective Nerve Root Block
__ Cervical __ thoracic __lumbar
☐ Discography
__ Thoracic __ lumbar
☐ Intrathecal Pump/Trial/Refill
__ Morphine __ Baclofen __ other
☐ IDET Procedure
☐ Sympathetic Block
__ Stellate __ Celiac
__ Lumbar __ Hypogastric
__ Ganglion of Impar
☐ Occipital Nerve Block
☐ Trial Spinal Cord Stimulator
☐ Diagnostic Nerve Block
☐ Nucleoplasty (Percutaneous)
☐ Electromyography (EMG)
☐ Botox Treatment for Spasticity, Trigger Points and Migraines
☐ Specific Level Desired (if applicable): _____

OTHER: _____

Please Include the Following:

☐ Face Sheet (demographics)
☐ Insurance Card (front & back)
☐ Referral or Authorization
☐ Clinical notes pertaining to patient's diagnosis
☐ Reports on diagnostic studies (MRI, CT, XRAY, EMG, etc.)

Thank you for your referrals!

If this is a first-time referral, how did you hear about us?

☐ Mailer ☐ Fax ☐ Periodical ☐ Patient ☐ Lunch/Dinner
☐ Other Provider ☐ Website ☐ Insurance Company ☐ Other

Revision 11/2014- this form is also online at www.valleypain.org