



3480 Wake Forest Rd., Suite 208 ♦ Raleigh, NC 27609 ♦ Phone (919) 781-4541 ♦ Fax (919) 781-4812

Date: _____ Patient: _____ Referring Provider: _____

Address: _____ DOB: _____ SS#: _____

Insurance: Primary _____ Secondary _____ Phone# _____

Diagnosis: _____

Imaging Studies: _____ (attach reports and ask patients to bring films if possible)

___ **Physiatry Consult:**

___ **First available** ___ **Dr. Bentley** ___ **Dr. Wilson**

___ **EMG/NCS:** **RUE LUE RLE LLE** (Please circle)

DIAGNOSTIC/THERAPEUTIC INJECTIONS:

___ **Epidural Steroid Injections:** ___ **Cervical** ___ **Lumbar**
___ **Series (per Physiatry)** ___ **One Epidural Injection**

___ **Diagnostic Spinal Nerve Block-specify nerve:** _____

___ **Sacroiliac Joint: Fluoroscopic/Anesthetic Arthrogram** **R L**

___ **Lumbar Discography: (Discs to study: _____)**

___ **Facet: ___ Joint injection**

___ **Diagnostic (medial branch) nerve block**

Joints to block: ___ per Physiatry ___ specific joints _____

___ **Sympathetic Block** ___ **Lumbar** ___ **Stellate ganglion**

___ **Shoulder: Fluoroscopic Arthrogram:** **R L** (___ Measure pain relief)

___ **Hip: Fluoroscopic/ Anesthetic Arthrogram:** **R L**

___ **Ankle: Fluoroscopic Arthrogram:** **R L** (___ Measure pain relief)

___ **Subtalar joint: Fluoroscopic Arthrogram:** **R L** (___ Measure pain relief)

___ **Other procedure/injection (specify: _____)**

***FOR INJECTIONS:** please instruct patient to remain off **ASPIRIN & NSAIDS** for **5-7 DAYS** prior to procedure. Patients on **ANTI-COAGULANTS** (including Aspirin) for health reasons must receive clearance from the prescribing physician to be off those medications for at least **5-7 DAYS** prior to procedure. Those on **COUMADIN** will need **INR/PT** within **24 HOURS** prior to procedure. Please have patient notify us at least **48 HOURS** prior to procedure if he/she has a contrast dye allergy.

Pre-cert required: Yes ___ No ___

Pre-cert: Yes ___ No ___

Fax to: 919-781-4812

Phone: 919-781-4541