INTEGRATIVE PAIN MANAGEMENT S.C.

Pain Management Referral Form- Please Have patient bring to appointment

Date:_____

Referring Physician:_____ **(P):**_____ **(F):**_____

❒ 555 South Washburn Street
Oshkosh, WI, 54904
(P): 920-230-7246
Fax: 920-230-6544

❒ 3108 Mid Valley Drive
De Pere, WI, 54115
(P): 920-532-9117
Fax: 920-532-9143

❒ 2323 N Casaloma Drive
Appleton, WI, 54915
(P): 920-230-7246
Fax: 920-230-6544

❒ Dr. John Joseph, MD ❒ Dr. Mazin Ellias, MD ❒ Dr. Nancy Bratanow, MD

❒ Dr. Karl Huebner, DC ❒ Julie Reynolds, NP

Patient Information

Patient Name (Last, First, MI):_____

Patient DOB:_____

Patient Phone:_____

Patient Insurance info:_____

Patient Address:_____

Symptoms/Diagnosis:_____

❒ Evaluate & Treat **❒ Consult Only**

❒ Selective Nerve Block level _____

❒ Diagnostic Facet Injection

❒ Diagnostic Discogram

❒ Chiropractic

❒ Evaluate for Dorsal Column Stimulator

❒ Prolotherapy/ PRP injection

❒ Medication Management

❒ Epidural Steroid Injection

❒ Botox Injection

❒ Trigger Point Injection

❒ Radiofrequency Denervation of _____

❒ Peripheral Nerve Block of _____

❒ Implantation of Spinal Cord Stimulator

❒ Acupuncture

❒ Other:_____

Is the patient on blood-thinners?: **Y** **N**

Is this Workman's Comp/PI? **Y** **N**

Doctor's Commments/Questions:

_____

_____

_____

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