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**CONSULTATION/REFERRAL FOR PAIN MANAGEMENT SERVICES**

Patient Name		Date	
Patient Phone Number(s)		Date of Birth	
Referring Physician Name	Referring Physician Phone	Referring Physician Fax	
Insurance Coverage:	<input type="checkbox"/> Private/Indemnity	<input type="checkbox"/> Medicare	<input type="checkbox"/> Worker's Compensation
	<input type="checkbox"/> HMO	<input type="checkbox"/> Cash/Other	
Patient Diagnosis:			
<b>The patient is being referred for the following service(s)</b>			
<input type="checkbox"/> Consultation and Management			
<input type="checkbox"/> Specify Level: _____ or Nerve: _____ or region: _____			
<input type="checkbox"/> Knee Joint Injection	<input type="checkbox"/> Hip Joint Injection	<input type="checkbox"/> Shoulder Joint Injection	<input type="checkbox"/> Other Joint Injection
<input type="checkbox"/> Caudal Epidural	<input type="checkbox"/> Lumbar Epidural	<input type="checkbox"/> Thoracic Epidural	<input type="checkbox"/> Cervical Epidural
<input type="checkbox"/> Translaminar	<input type="checkbox"/> Transforaminal	<input type="checkbox"/> Selective Nerve Root	<input type="checkbox"/> Facet
<input type="checkbox"/> Sphenopalatine Ganglion	<input type="checkbox"/> Stellate Ganglion	<input type="checkbox"/> Lumbar Sympathetic	<input type="checkbox"/> Intercostal Block
<input type="checkbox"/> Occipital Nerve	<input type="checkbox"/> Peripheral Nerve	<input type="checkbox"/> Trigger Point	<input type="checkbox"/> Radio Frequency
<input type="checkbox"/> Spinal Cord Stimulator	<input type="checkbox"/> Other (please specify): _____		
_____ Christopher Zarembinski, MD			
Thank you for this referral Please fax any related diagnostic information and test results to (213) 427-3659			
<b>Proven to renew the knee joint</b>			