Referral for Pain Management

Kamyar Assil, MD

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(805) 497-8616

Please complete this form and fax to: (805) 777-7376

REFERRING PHYSICIAN:

Physician's Name | Practice Name | Physician's Phone | Fax

PATIENT INFORMATION: (Please fill out)

Last Name | First Name | DOB | Patient's Phone | Referral Date

PATIENT DIAGNOSIS OR CHIEF COMPLAINT: (Please fill out)

THE PATIENT IS BEING REFERRED FOR: (Please fill out)

☐ Pain Consultation: In Office

☐ Epidural Steroid Injection: *Lumber*☐ *Cervical*☐ *Thoracic*☐

☐ Facet Joint Diagnostic Injection: *Lumbar*☐ *Cervical*☐ *Thoracic*☐

☐ Evaluation for Spinal Cord Stimulation

☐ Evaluation for Intrathecal Drug Therapy (Pump)

☐ Other _____

REQUIRED ADDITIONAL INFORMATION: Please include patient's current demographics, patient's insurance card, authorization # for appropriate referral, X-rays, imaging, studies and/or any other pertinent medical documentation.