

INTERVENTIONAL PAIN MANAGEMENT

DWAYNE E. JONES, MD, LLC

FAX REFERRAL FORM

(PLEASE CIRCLE PREFERRED LOCATION AND FAX FORM)

Lee's Summit Medical Center
2000 SE Blue Parkway, # 240
Lee's Summit, MO 64063
Scheduling: 816.282.5915
Fax: 816.282.5808

Centerpoint Ambulatory Surgery
19550 E. 39th Street S #100
Independence, MO 64057
Scheduling: 816.268.6395
Fax: 913.381.0979

Blue Valley Surgical Center
12850 Metcalf Road, Ste. 220
Overland Park, KS 66213
Appointments: 913.378.1365
Fax: 913.428.4710

North Kansas City Hospital
2790 Clay Edwards Drive
North Kansas City, MO 64116
Scheduling: 816.268.6395
Fax: 913.381.0979

Name: _____ Date: _____

DOB: _____ Home Phone #: _____

Cell #: _____ Work Phone #: _____

Chief Complaint/Diagnosis: _____

PLEASE FAX COPIES OF ANY DIAGNOSTIC REPORTS (MRI, CT, X-RAY, ETC.), AS WELL AS THE MOST RECENT PHYSICIAN'S NOTES, PATIENT DEMOGRAPHICS AND INSURANCE INFORMATION RELATED TO THE PATIENT ALONG WITH THIS REQUEST FORM.

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|---|--|
| <input type="checkbox"/> General Pain Mgmt. Consultation/Evaluation | <input type="checkbox"/> MILD, Lumbar Spinal Stenosis |
| <input type="checkbox"/> Workman's Compensation Evaluations/Second Opinions | <input type="checkbox"/> Occipital Nerve Block |
| <input type="checkbox"/> Consultation for Medication Management (Non-Narcotic) | <input type="checkbox"/> Intercostal Nerve Block |
| <input type="checkbox"/> Evaluation for Non-Narcotic Treatment Options for Cervicogenic (Non-Migraine Type) Headache | <input type="checkbox"/> Celiac Plexus Block |
| <input type="checkbox"/> Selective/Diagnostic Nerve Block Specific Level Desired (if applicable): | <input type="checkbox"/> Trigeminal Nerve Block |
| <input type="checkbox"/> Epidural Steroid Injection <input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar | <input type="checkbox"/> Stellate Ganglion Block |
| <input type="checkbox"/> Facet Joint Injection <input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar | <input type="checkbox"/> Lumbar Sympathetic Block |
| <input type="checkbox"/> Discography <input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar | <input type="checkbox"/> IDET Procedure |
| <input type="checkbox"/> Evaluation for Spinal Cord Stimulation | <input type="checkbox"/> Nucleoplasty (Percutaneous Disc Decompression) |
| <input type="checkbox"/> Epidural Neuroplasty (Adhesiolysis) | <input type="checkbox"/> Treatment for Compression Fxs:
<input type="checkbox"/> Kyphoplasty/Vertebroplasty |
| <input type="checkbox"/> Radiofrequency Neurolysis <input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar <input type="checkbox"/> Knee | <input type="checkbox"/> Treatment for Fibromyalgia/Myofascial Pain) |
| <input type="checkbox"/> Trigger Point Injection | |
| <input type="checkbox"/> Joint Injection: <input type="checkbox"/> Sacroiliac <input type="checkbox"/> Hip <input type="checkbox"/> Shoulder <input type="checkbox"/> Knee
<input type="checkbox"/> Ankle <input type="checkbox"/> Temporomandibular | |

Other: _____

Referring Physician: _____ City & State: _____

Contact Telephone: _____ Contact Fax: _____

Email Address: _____

www.dejonesmd.com

Thank you for your referral to our practice!

-Dwayne E. Jones, MD-