

INTERVENTIONAL PAIN MANAGEMENT

DWAYNE E. JONES, MD, LLC

FAX REFERRAL FORM

PLEASE CIRCLE PREFERRED LOCATION AND FAX FORM

North Kansas City Hospital · 2790 Clay Edwards Drive, 7th Floor
North Kansas City, MO 64116
Phone: 816.268.6395 · Fax: 913.381.0979

Harrison County Community Hospital · 2600 Miller Street
Bethany, MO 64424
Phone: 660.425.0253 · Fax: 660.425.8235

Lee's Summit Medical Center · 2000 SE Blue Parkway, Suite 240
Lee's Summit, MO 64063
Phone: 816.282.5915 · Fax: 816.282.5808

Hedrick Medical Center · 2799 N Washington Street
Chillicothe, MO 64601
Phone: 660.214.8420 · Fax: 660.214.8466

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.

- | | |
|--|--|
| <input type="checkbox"/> General Pain Mngt. Consult/Evaluation | <input type="checkbox"/> Occipital Nerve Block |
| <input type="checkbox"/> Work Comp Evaluation | <input type="checkbox"/> Intercostal Nerve Block |
| <input type="checkbox"/> Second Opinion | <input type="checkbox"/> Celiac Plexus Block |
| <input type="checkbox"/> Consult for Med Management | <input type="checkbox"/> Trigeminal Nerve Block |
| <input type="checkbox"/> Eval for Non-Narcotic Treatment/Cervogenic Headache | <input type="checkbox"/> Stellate Ganglion Block |
| <input type="checkbox"/> Selective Diagnosis Nerve Block Specified Level Desired _____ | <input type="checkbox"/> Lumbar Sympathetic Block |
| <input type="checkbox"/> Epidural Steroid Injection <input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar | <input type="checkbox"/> Nucleoplasty, Percutaneous Disc Decompression |
| <input type="checkbox"/> Facet Joint Injection <input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar | <input type="checkbox"/> Treatment for Compression Fractures |
| <input type="checkbox"/> Discography <input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar | <input type="checkbox"/> Kyphoplasty <input type="checkbox"/> Vertebroplasty |
| <input type="checkbox"/> Radiofrequency of the <input type="checkbox"/> Hip <input type="checkbox"/> Knee <input type="checkbox"/> SI Joint | <input type="checkbox"/> Treatment for Fibromyalgia/Myofascial Pain |
| <input type="checkbox"/> Spinal Cord Stimulation Evaluation | |
| <input type="checkbox"/> Epidural Neuroplasty (Adhesiolysis) <input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic | |
| <input type="checkbox"/> Lumbar <input type="checkbox"/> Knee | |
| <input type="checkbox"/> Trigger Point Injection | |
| <input type="checkbox"/> Joint Injection <input type="checkbox"/> SI <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: _____

THANK YOU FOR YOUR REFERRAL TO OUR PRACTICE!
DWAYNE E. JONES MD