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PATIENT INFORMATION

Patient Last _____ First Name _____ Middle _____

Birth Date ____/____/____ Best Phone Number _____

Address _____

City _____ State _____ Zip _____

Open Workers Comp: Yes / No Open Motor Vehicle Accident: Yes / No Date of Injury: ____/____/____

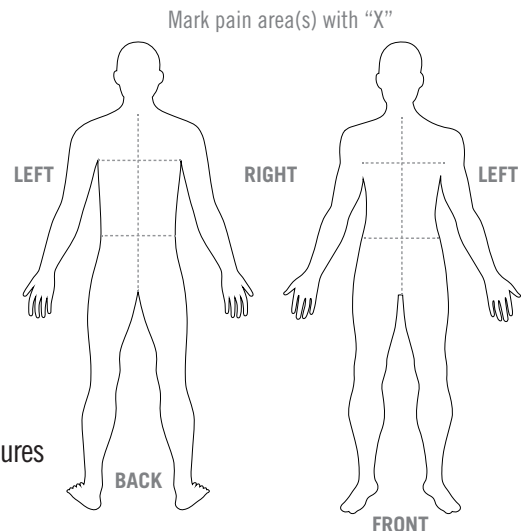
Insurance Company _____ Claim/ID#/Group _____

Adjuster Name _____ Phone Number _____

Chief Complaint/Diagnosis _____

**PLEASE FAX COPIES OF IMAGING REPORTS (MRI, CT, X-RAY, ETC.) & OFFICE NOTES.
PLEASE INDICATE THE PROCEDURE SIDE/SITE OR INDICATE EVALUATE AND TREAT.**

- | | |
|---|--|
| <input type="checkbox"/> Epidural Steroid Injection | <input type="checkbox"/> Peripheral Nerve Stimulation |
| <input type="checkbox"/> Selective Nerve Root Block | <input type="checkbox"/> Ketamine Infusions |
| <input type="checkbox"/> Facet Joint Injection | <input type="checkbox"/> Sympathetic Block(Lumbar,Stellate) |
| <input type="checkbox"/> Medial Branch Block/
Radiofrequency | <input type="checkbox"/> Spinal Cord Stimulator Trial/Implant |
| <input type="checkbox"/> Sacroiliac Joint Diagnostic/Injection | <input type="checkbox"/> Discography |
| <input type="checkbox"/> Percutaneous Discectomy | <input type="checkbox"/> Joint (Shoulder, Elbow, Hip, Knee, Ankle, Foot) |
| <input type="checkbox"/> Kyphoplasty/Vertebroplasty | <input type="checkbox"/> Consult for treatment |
| <input type="checkbox"/> Trigger Point Injections | <input type="checkbox"/> Medical Cannabis Program |
| <input type="checkbox"/> Botox for Migraine/Cervical Dystonia | <input type="checkbox"/> Minimally Invasive Endoscopic Spine Procedures |
| <input type="checkbox"/> Platelet Rich Plasma Therapy (PRP) | <input type="checkbox"/> Prolotherapy _____ |
| | <input type="checkbox"/> Other _____ |



REFERRING PROVIDER INFORMATION

Provider Name _____ Provider Clinic _____

Contact Person _____ Phone _____ Date ____/____/____