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**Matthew G. Thorson, MD**
Double Board Certified
Anesthesiology/Pain Medicine

**Louis C. Saeger, MD**
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## PATIENT INFORMATION

**Patient Last:**________________________**First Name:** ____________________ **Middle**____ **DOB**:____ /____ /_____
**Best Phone #**:_____________________ 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#**________________________________________

**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**

- ☐ Epidural Steroid Injection
- ☐ Selective Nerve Root Block
- ☐ Facet Joint Injection
- ☐ Medial Branch Block/Rhizotomy
- ☐ Sacroiliac Joint Diagnostic/Injection
- ☐ Percutaneous Discectomy
- ☐ Discography
- ☐ Trigger Point Injections
- ☐ Botox for Migraine/Cervical Dystonia
- ☐ Medical Cannabis Program
- ☐ Platelet Rich Plasma Therapy
- ☐ Peripheral Nerve Block
- ☐ Celiac Plexus Block
- ☐ Stellate Ganglion Block
- ☐ Spinal Cord Stimulator Trial/Implant
- ☐ Intrathecal Drug Pump Trial/Implant
- ☐ Kyphoplasty/Vertebroplasty
- ☐ Joint (Shoulder,Elbow, Hip,Knee,Ankle,Foot)
- ☐ Consult for treatment
- ☐ Prolotherapy
- ☐ Other: ______________________

**Specific Level desired(if applicable)**______________________________ **at proceduralist's discretion**

## REFERRING PROVIDER INFORMATION

**Provider Name:**___________________________ **Provider Clinic:** _____________________________________
**Contact Person**__________________________ **Phone**____________________**Date** ____________________

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