Advanced Spine & Pain Clinics of MN®

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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_____

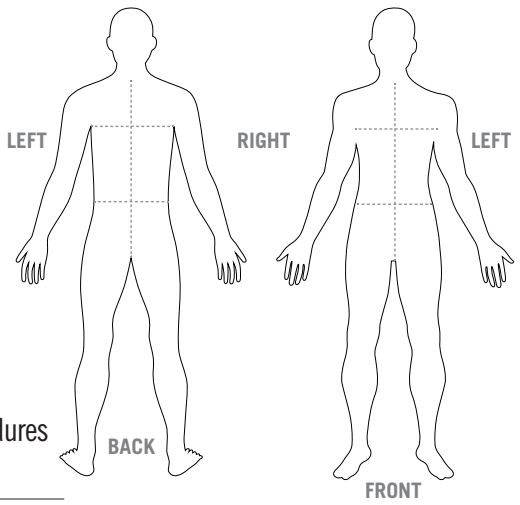
Chief Complaint/Diagnosis _____

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

❑ Epidural Steroid Injection
❑ Selective Nerve Root Block
❑ Facet Joint Injection
❑ Medial Branch Block/Rhizotomy
❑ Sacroiliac Joint Diagnostic/Injection
❑ Percutaneous Discectomy
❑ Discography Kyphoplasty/Vertebroplasty
❑ Trigger Point Injections
❑ Botox for Migraine/Cervical Dystonia
❑ Platelet Rich Plasma Therapy (PRP)

❑ Peripheral Nerve Block
❑ Ketamine Infusions
❑ Stellate Ganglion Block
❑ Spinal Cord Stimulator Trial/Implant
❑ Radiofrequency ablation
❑ Joint (Shoulder, Elbow, Hip, Knee, Ankle, Foot)
❑ Consult for treatment
❑ Medical Cannabis Program Prolotherapy
❑ Minimally Invasive Endoscopic Spine Procedures
Other _____

Mark pain area(s) with "X"



Specific Level desired(if applicable) _____ at proceduralist's discretion.

REFERRING PROVIDER INFORMATION

Provider Name _____ Provider Clinic _____

Contact Person_____ Phone _____ Date _____/_____/_____