Advanced Pain & Spine Institute OF MONTANA

2835 Fort Missoula Road, Suite 102
Missoula, MT 59804
(406)541-7246

Outreach Clinic (Mondays)
1224 West Main Street
Hamilton, MT 59840

Please complete this form and fax to: (406)721-8298

*In order to schedule your patient please include the last six months of their medical and radiology records.

SERVICES-

- ☐ **MEDICAL MANAGEMENT:** An evaluation for chronic opioid therapy. Before assuming chronic opioid therapy the patient is placed into a screening protocol including a pain psychology evaluation, drug screening and opioid contract.
- ☐ **CHRONIC PAIN MANAGEMENT:** Please evaluate the patient in your multidisciplinary program with physical therapy, pain psychotherapy, medication management and possible interventional pain procedures.
- ☐ **SPINE REFERRAL:** A multidisciplinary approach to spine care including physical therapy, pain and interventional medicine, neurosurgery or orthopedic surgery, psychotherapy and diagnostic imaging studies.
- ☐ **CONSULTATION WITH PROCEDURE AS APPROPRIATE:** An evaluation for interventional pain procedures. (Please check desired choice if known)
- ☐ **ONE TIME PAIN CONSULTATION:** Recommendations for how we can treat this patient in our clinic.

INTERVENTIONAL PAIN PROCEDURES-
(Must be pre-authorized)

DX: _____

- ☐ Interlaminar Steroid Level: _____
- ☐ Transforaminal Epidural Level Side: R _____ L _____
- ☐ Selective Nerve Root Block Level Side: R _____ L _____
- ☐ Facet Joint Injection Level Side: R _____ L _____
- ☐ SI Joint Injection R L Bil.
- ☐ Discogram Levels: _____
- ☐ Radio Frequency Ablation
- ☐ Medial Branch Blocks
- ☐ Other (Please specify) _____

Referring Physician | Office Contact | Phone | Fax

PATIENT INFORMATION-

Last Name | First Name | MI | SSN | DOB

Address | City | State | Zip

Home Phone | Work Phone | Cell Phone

INSURANCE INFORMATION-

Primary Insurance | Policy # | Group # | Subscriber DOB

Secondary Insurance | Policy # | Group # | Subscriber DOB

WORK RELATED? YES / NO AUTO INJURY? YES / NO DATE OF INJURY _____/_____/_____

Employer: _____

HAS PATIENT HAD RECENT:

MRI YES NO Where/When _____

X-RAY YES NO Where/When _____

CT YES NO Where/When _____

IS PATIENT TAKING: Antibiotics? YES / NO

Blood Thinners? YES / NO : _____

DOES PATIENT HAVE: Liver Problems? (Hep C) YES / NO Diabetes? YES / NO

Allergy to Contrast Dye, Latex, Iodine or Shellfish? YES / NO