Physical Medicine & Rehabilitation

A Department of Rutland Regional Medical Center

Referral Form

160 Allen Street, Rutland VT 05701
P: 802.747.3633 F: 802.747.6223

Name: _____ DOB: _____ SSN: _____ (last 4 digits)

Address: _____

Preferred Phone: _____

Primary Ins: _____ Policy # _____ Group # _____

Secondary Ins: _____ Policy # _____ Group # _____

Diagnosis/Reason for Visit: _____

(must be included to schedule appointment)

Type of Visit: ❒ **Consult** ❒ **Other** (describe):_____

❒ **Procedure Only** (check appropriate box below and circle corresponding information):

❒ **EMG** ❒ R ❒ L ❒ Bilateral ❒ Upper ❒ Lower

❒ **Trigger Point Injection** ❒ **R** ❒ **L** Location:	❒ **Epidural Steroid Injection** ❒ R ❒ L ❒ Cervical ❒ Thoracic ❒ Lumbar ❒ Interlaminar ❒ Transforaminal Level(s): ****Please complete checklist on back****
❒ **Carpal Tunnel Injection** ❒ **R** ❒ **L**	❒ **Facet Joint Steroid Injection** ❒ R ❒ L ❒ Thoracic ❒ Lumbar Level(s):
❒ **Hip Joint Steroid Injection** (under Fluoroscopy) ❒ **R** ❒ **L**	❒ **Diagnostic Medial Branch Block** *(x2 - contingent upon results of 1st DXMBB)* ❒ R ❒ L ❒ Bilateral ❒ Cervical ❒ Lumbar Level(s):
❒ **Sacroiliac Joint Injection** (under Fluoroscopy) ❒ **R** ❒ **L**	❒ **Radio Frequency Denervation** *(contingent on results of DXMBB x2)* ❒ R ❒ L ❒ Bilateral ❒ Cervical ❒ Lumbar Level(s):
❒ **Other Injection** ❒ R ❒ L Location:	

Requesting Physician Signature:_____ ___Date:_____

Phone: _____ Fax: _____

Please forward the following patient information: ➔List of Medications/Allergies
➔Pertinent history, x-ray and/or exam findings

PLEASE FAX TO 802.747.6223 and notify the patient that we will call them with the appointment time. Thank you.

Complete the checklist below for <u>Epidural Steroid Injections ONLY</u>

When ordering for radicular syndrome, sciatica, or radiculopathy, (extremity pain) please indicate which of the following conditions are met:

- Please select the appropriate condition:
  - ☐ Spinal stenosis
  - ☐ Degenerative disc disease
  - ☐ Disc herniation
  - ☐ Spondylolisthesis
  - ☐ Post herpetic neuralgia.

- If the patient does not have radiculopathy, and simply has spinal pain, please confirm the presence of one of the following:
  - ☐ Severe degenerative disc disease
  - ☐ Central stenosis
  - ☐ Herniated disc.

- **<u>And</u>** at least one of the following statements:
  - ☐ Failure to improve after 4 weeks of conservative treatments (ie: medications, activity modification, PT, or chiropractic) unless acute severe disabling pain with loss of function at work or home
  - ☐ Medical condition that precludes surgery or other nonmedical care
  - ☐ Patient is a surgical candidate but wishes nonsurgical treatment
  - ☐ Epidural is an adjunct to provide temporary relief to facilitate exercise or rehabilitation
  - ☐ Prior successful epidural for the same condition with at least three months relief