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Interventional Pain Management
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Brain Injury Medicine
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Today's Date: _____

PATIENT REFERRAL FORM

Patient Name: _____ DOB: _____ Phone Number: _____

Referring Physician: _____ Contact Email: _____

Physician Phone: _____ Physician Fax: _____

Diagnosis: _____

Procedure Requested: _____

CONSULTATION:

- Evaluate and Treat
- Functional Rehabilitation / Optimization

ELECTRODIAGNOSTIC EVALUATION:

- Upper Extremity Left Right Bilateral
- Lower Extremity Left Right Bilateral

SPINAL PROCEDURES: Right Left Bilateral

- Epidural Injection Level(s): _____
- Facet Joint Injection Level(s): _____
- Medial Branch Block followed by Radiofrequency Ablation/ Rhizotomy Level(s): _____
- Sacroiliac Joint Injection
- Discography Level(s): _____
- Platelet Rich Plasma (PRP) Injection* Specify: _____

PERIPHERAL JOINT/MSK PROCEDURES: Right Left Bilateral

- Trigger Point Injection
 - Joint Injection with Ultrasound or Fluoro Shoulder Elbow Wrist Hip Knee Ankle
 - Carpal Tunnel Injection
 - Platelet Rich Plasma (PRP) Injection* Specify: _____
 - Botulinum toxin Injection* Specify: _____
- *Not covered by insurance

SYMPATHETIC BLOCK PROCEDURES: Right Left Bilateral

- Stellate Ganglion Block Lumbar Sympathetic Block Superior Hypogastric Block
- Celiac Ganglion Block Impar Block

NEUROMODULATION/ OTHER PROCEDURES

- Spinal Cord Stimulator Peripheral Nerve Stimulator Trial Implant
- Intrathecal Baclofen Pump
- Kyphoplasty Level(s): _____
- Vertiflex Interspinous Spacer Level(s): _____
- Shockwave Therapy* Specify: _____