Hillside Pain Management

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Hanover, PA 17331
Phone: 717-632-5478 Fax: 717-633-0257

Request for Evaluation

PLEASE COMPLETE FORM AND FAX WITH SUPPORTING MEDICAL RECORDS TO 717-633-0257. ONCE ALL INFORMATION IS RECEIVED, WE WILL CALL THE PATIENT TO SET UP AN APPOINTMENT. THANK YOU.

Patient Name: _____ Sex: ☐ Male ☐ Female

Address: _____

City: _____ State: _____ Zip: _____ Social Security #: _____

Home Phone: _____ Other Phone: _____ DOB: _____

Referring Physician: _____ Specialty: _____

Address: _____ Phone: _____ Fax: _____

Primary Care Physician: _____ Phone: _____ Fax: _____

Address: _____

Chief Complaint: _____

Primary Insurance: _____ Secondary Insurance: _____

Workman's Comp ☐ Medicare ☐ Managed Care ☐ Auto ☐

Policy#: _____ Referral form needed: ☐ Yes ☐ No

Please attach copy of *insurance card(s)* front/back, *most recent office note* including pain medications given.

Please fax any recent results of the following:

Any recent X-rays, MRIs or CT scans? ☐ Yes ☐ No Done Where? _____

Reason for Referral:

- ☐ Consult and Advise Only
- ☐ Evaluate and Treat
- ☐ If Specific Procedure Requested, Please √
  - ☐ Cervical Epidural Steroid Injection - Level _____
  - ☐ Thoracic Epidural Steroid Injection -Level _____
  - ☐ Lumbar Epidural Steroid Injection -Level _____
  - ☐ Facet Joint Injection/ MBNB with consideration for RadioFrequency
  - ☐ Nerve Block – Location _____
  - ☐ Intercostal Nerve Block
  - ☐ Lumbar Sympathetic Nerve Block
  - ☐ Occipital Nerve Block
  - ☐ Peripheral Nerve Block
  - ☐ Stellate Ganglion Block
  - ☐ Trigger Point Injection
  - ☐ Spinal Cord Stimulator Trial
  - ☐ Cryotherapy
  - ☐ Cervical Discogram – Levels _____
  - ☐ Lumbar Discogram – Levels _____
  - ☐ Other _____
- ☐ Following treatment, patient to return to referring physician for further evaluation if needed.
- ☐ Surgical intervention being considered? ☐ Yes ☐ No