



Pain Management Request Check List - Fax to: (502) 379-4146

Member Name:

ID#:

Diagnosis and Diagnosis Code:

Requested Procedure & Procedure Code:

Vertebral level (s) or body part(s) for procedure (Please specify right vs. left, if applicable.):

Current pain level on a 1-10 VAS scale:

Has the Patient had previous any injections/procedures before? If so, what type, when, what percentage of pain relief was obtained for each & for how long?

Current medications - dosage/ frequency/ start date, *if any*:

Anti-Inflammatories, steroidal or non-steroidal (dosage/ frequency/ start date), *if any*:

Muscle Relaxants (dosage/ frequency/ start date), *if any*:

Pain Medications (dosage/ frequency/ start date), *if any*:

Physical medicine (Physical therapy with modalities, chiropractic, or osteopathic medicine) - Please include start date/ sessions/results, *if any*:

Any previous surgery in the same/adjacent body region?

Please include any diagnostics reports such as X-rays, CT, MRI, EMGs, etc. Also please include any laboratory test results including any recent CBC, chemistries, SED, ANA, rheumatoid factor, uric acid, or C-reactive protein tests.