Joseph M. Oppong, Jr., MD.
Akara Forsythe, MD.
201 Pine Bluff Rd., Ste 1
Salisbury, MD 21801
Ph: (410) 648-2000 Fax: (410) 946-8360

REFERRAL TO INTERVENTIONAL PAIN MANAGEMENT

PLEASE FAX THIS COMPLETED FORM ALONG WITH OFFICE NOTES, IMAGING, AND STUDIES TO 410-946-8360.

REFERRING PHYSICIAN/PROVIDER:

PHYSICIAN'S NAME: _____ PRACTICE NAME: _____

DATE:_____ PHONE: _____ FAX: _____

PATIENT INFORMATION:

LAST NAME: _____ FIRST NAME: _____ MIDDLE INITIAL: _____

DATE OF BIRTH: _____ PHONE: _____

SERVICES:

- ☐ CONSULTATION ONLY
- ☐ REFERRAL WITH ONGOING MANAGEMENT
- ☐ CONSULTATION WITH PROCEDURE AS APPROPRIATE
- ☐ PROCEDURES ONLY
  (PLEASE INDICATE PROCEDURE FROM THE LIST BELOW)

PROCEDURE ONLY:

- ☐ EPIDURAL STEROID LEVEL _____
- ☐ TRANSFORAMINAL EPIDURAL LEVEL _____
  SIDE: R _____ L_____
- ☐ FACET JOINT INJECTION LEVEL _____
  SIDE: R _____ L_____
- ☐ TRIGGER POINT INJECTION
  AREA: _____
- ☐ DISCOGRAM
  AREA: _____
- ☐ NEUROSTIMULATION (SPINAL CORD & PERIPHERAL)
- ☐ INTRATHECAL DRUG DELIVERY
- ☐ OTHER (PLEASE SPECIFY)

_____

_____

_____

DIAGNOSIS:

- ☐ CHRONIC BACK AND LEG PAIN
- ☐ FAILED BACK SURGERY SYNDROME
- ☐ COMPLEX REGIONAL PAIN SYNDROME (RSD/CAUSALGIA)
- ☐ POSTLAMINECTOMY PAIN SYNDROME (CERVICAL & LUMBAR)
- ☐ RADICULOPATHY
- ☐ MALIGNANT (CANCER) PAIN
- ☐ ARACHNOIDITIS
- ☐ NEURALGIA
- ☐ NEUROPATHIC PAIN
- ☐ CHRONIC PAIN SYNDROME
- ☐ OTHER: _____

FOLLOW UP CARE:

- ☐ I WOULD LIKE TO SEE THIS PATIENT FOR A FOLLOW-UP APPOINTMENT AFTER THE PROCEDURE
- ☐ I AM REFERRING THE PATIENT FOR LONG-TERM CARE

OFFICE NOTES:

_____

_____

_____

OUR OFFICE WILL CONTACT YOUR PATIENT WITHIN 24 HOURS TO SCHEDULE AN APPOINTMENT