Virginia Interventional Pain & Spine Center

REFERRING-PHYSICIAN FORM-SURGEON

Virginia Interventional Pain & Spine Center, Inc. 3800 Electric Road, Suite 307, Roanoke, VA 24018
Questions: Please contact us at: Phone: (540) 777 - 0090 Fax: (540) 206 -3826 Info@vapainsc.com
Consultation Request Form- fax to (540) 206 -3826

☐ Emergent ☐ Urgent ☐ Routine

Check one or both of our providers:

Office Consult: ☐ Chheany Ung, M.D. ☐ Arun Sun, PA-C ☐ Kate Duff, PA-C ☐ First Available

REFERRING PHYSICIAN

Physician Name: ____________________ Practice Name: ____________________

Date: ____________________ Phone: ____________________ Fax: ____________________

Reason for Referral: ____________________

PATIENT INFORMATION

Last Name: ____________________ First Name: ____________________ Middle Initial: ____________________

Date of Birth: ____________________ Phone: ____________________

DIAGNOSIS:

- ☐ Acute lumbar strain with/without leg pain
- ☐ Chronic back and leg pain
- ☐ Complex regional pain syndrome/CRPS (formerly RSD)
- ☐ Failed back surgery syndrome
- ☐ Herniated disc lumbar/thoracic/cervical
- ☐ Lumbar/Thoracic/Cervical DDD
- ☐ Lumbar/Thoracic/Cervical facet syndrome
- ☐ Lumbar/Thoracic/Cervical spinal stenosis
- ☐ Malignant pain
- ☐ Myofascial pain syndrome
- ☐ Neuralgia
- ☐ Radiculopathy (Lumbar/Thoracic/Cervical)
- ☐ Sacroiliitis
- ☐ Shingles/Post herpetic Neuralgia
- ☐ Vertebral Fractures (Sacral/Lumbar/Thoracic)
- ☐ Other

PROCEDURES:

- ☐ Acupuncture
- ☐ Discography : Level ....
- ☐ Epidural:
  - ◯ Interlaminar : Level .... Side Ⓡ Ⓛ Ⓑ
  - ◯ Transforaminal: Level .... Side Ⓡ Ⓛ Ⓑ
- ☐ Facet joint injection
  - ◯ Cervical ◯ Thoracic ◯ Lumbar Side Ⓡ Ⓛ Ⓑ
- ☐ Intradiscal electrothermal therapy (IDET)
- ☐ Intrathecal drug delivery therapies
- ☐ Kyphoplasty: Level ....
- ☐ Minimally invasive lumbar decompression for spinal stenosis (MILD)
- ☐ Prolotheraphy
- ☐ Radiofrequency therapies (Denervation/Rhizotomy)
- ☐ Sacroiliac joint injections Side Ⓡ Ⓛ Ⓑ
- ☐ Spinal cord/peripheral nerve stimulation
- ☐ Sympathetic nerve blocks
- ☐ Trigger point injection
  - Area: ....
- ☐ Other (please specify) ....

Physician's Signature: ____________________ Date: ____________________

Please fax request, patient's demographic sheet, office notes, imaging studies and referral if needed to (540) 206 -3826
**** Please note, we do not accept Medicaid or Virginia Premier****
Our office will contact your patient within 24 hours to schedule an appointment