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Date: _____

Patient Name: _____ SS#: _____

Patient Address: _____

DOB: _____ Home Phone #: _____ Work Phone #: _____

Insurance: _____

Previous Pain Clinic: Yes__ No__ Workers Comp: Yes__ No__ W/C Phone #: _____

Reason for Referral/Pain Diagnosis: _____

*** PLEASE FAX COPIES OF ANY DIAGNOSTIC REPORTS (MRI, CT, X-RAY, ETC.), AS WELL AS THE MOST RECENT PHYSICIAN'S NOTES, PATIENT DEMOGRAPHICS AND INSURANCE INFORMATION RELATED TO THE PATIENT ALONG WITH THIS REQUEST FORM. ***

- | | |
|------------------------------------------------------------------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> Pain Evaluation & Consultation or Evaluation & Treatment | <input type="checkbox"/> Nucleoplasty (Percutaneous) |
| <input type="checkbox"/> Diagnostic Nerve Block | <input type="checkbox"/> IDET Procedure |
| <input type="checkbox"/> Epidural Steroid Injection
___cervical ___thoracic ___lumbar | <input type="checkbox"/> Lumbar Sympathetic Block |
| <input type="checkbox"/> Facet Joint injection
___cervical ___thoracic ___lumbar | <input type="checkbox"/> Occipital Nerve Block |
| <input type="checkbox"/> Selective Nerve Root Block
___cervical ___thoracic ___lumbar | <input type="checkbox"/> Stellate Ganglion Block |
| <input type="checkbox"/> Discography
___cervical ___thoracic ___lumbar | <input type="checkbox"/> Trial Spinal Cord Stimulator |
| <input type="checkbox"/> Facet Rhizotomy | <input type="checkbox"/> Diagnostic Lumbar Puncture |
| <input type="checkbox"/> Sacroiliac Joint Injection | <input type="checkbox"/> Celiac Plexus Block |
| <input type="checkbox"/> Specific Level Desired (If applicable): _____ | <input type="checkbox"/> Epidural Blood Patch |
| | <input type="checkbox"/> Other _____ |

Referring Physician: _____ Contact Telephone: _____

Referring Physician NPI#: _____