UTAH VASCULAR CLINIC

Request for Pain Management Services

Fax: (801) 262-1533 Scheduling: (801) 281-0027
650 East 4500 South Suite100, Salt Lake City, Utah 84107

Patient Name:_____ DOB:_____

Patient's Phone:_____ Referring Physician:_____

Office Phone:_____ Diagnosis/Symptoms:_____

Insurance Carrier(s):_____

○ **Selective Nerve Root Block** ○ **Facet Injection** ○ **Medial Branch Block**
__Diagnostic __Therapeutic Side/Level(s):_____

○ **Epidural Steroid Injection** __Nonselective (Interlaminar) __Transforaminal Side/Level(s):_____

○ **Joint Injection** __Sacroiliac R / L __Shoulder R / L __Hip R / L Other:_____

○ **Clinical Consultation** __Vertebroplasty __Tumor Ablation Other:_____

○ **Epidural Blood Patch**

Comments:

Is the patient on blood thinners?_____ Date Stopped:_____
Please note that blood thinners must be stopped several days prior to interventional procedures

Check if one applies: Coumadin_____ Heparin_____ Plavix_____ Other_____

Provider Signature:_____ Date:_____