

Provider Referral

PHONE: 563-344-1050

FAX: 563-424-4579

JOHN B. DOOLEY, M.D.



PLEASE SELECT A LOCATION:

903 Oak St., Burlington, IA 2180 Norcor Ave., Suite B, Coralville, IA 5515 Utica Ridge Rd #600, Davenport, IA

Please send pertinent notes and images by fax or scan and submit to scheduling@pcipain.com. We will contact your patient within 24 hours and keep you informed. We look forward to assisting your patients.

Patient Name: _____ Today's Date: _____

Home#: _____ Cell#: _____ Work#: _____

Insurance Carrier: _____ Date of Birth: _____

REQUESTING PROVIDER INFORMATION:

Name: _____ Specialty: _____

Phone#: _____ Fax#: _____

DIAGNOSIS:

- | | | | |
|--|--|-------------------------------------|---|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Sacroiliitis | <input type="checkbox"/> Migraine | <input type="checkbox"/> Low Back/Radicular Pain |
| <input type="checkbox"/> Cervical/Radicular Pain | <input type="checkbox"/> Discogenic Pain | <input type="checkbox"/> CRPS/RSD | <input type="checkbox"/> Peripheral Neuropathy |
| <input type="checkbox"/> Compression Fx | <input type="checkbox"/> Facet Pain | <input type="checkbox"/> Nerve Pain | <input type="checkbox"/> Stenosis/Neurogenic Claudication |
- Other _____

REQUESTED SERVICE: *(please select)*

Interventional Consultation:

Is the patient taking an anti-coagulant? _____ Name: _____

Medical Management:

Opioids trialed: _____ If yes, how long? _____

Evaluate and Treat

Specific pain location: _____

PROCEDURE: *(please select)*

- | | |
|--|---|
| <input type="checkbox"/> Epidural Steroid Injection (Lumbar, Thoracic, Cervical) | <input type="checkbox"/> Stellate Ganglion Block |
| <input type="checkbox"/> Facet Joint Block/Medial Branch Block | <input type="checkbox"/> Lumbar Sympathetic Block |
| <input type="checkbox"/> RF Rhizotomy/Nerve Ablation | <input type="checkbox"/> Spinal Cord Stimulator |
| <input type="checkbox"/> Platelet Rich Plasma Regeneration | <input type="checkbox"/> Vertebroplasty/Kyphoplasty |
| <input type="checkbox"/> Intrathecal Pain Pump | <input type="checkbox"/> Peripheral Nerve Blocks |
| <input type="checkbox"/> Selective (Diagnostic) Nerve Block: Level(s) _____ | <input type="checkbox"/> Orthovisc Injections |
| <input type="checkbox"/> Joint Injections: _____ | <input type="checkbox"/> Ketamine Infusion |