WellSpine
A Division of Carolina Spine & Neurosurgery Center

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Chip Thompson, M.D.
Board Certified in Anesthesiology & Pain Medicine

Referring Physician ________________________________ NPI# ____________________

Referring Physician Specialty ____

Contact Person____________________ Phone # ______________ Ext_____ Fax # ____________________

Patient Name ________________________________ ☐ Male ☐ Female

Date of Birth ____________________ Social Security # ____________________________

Mailing Address ____

City / State / Zip ____

Phone #'s (home) ____________________ (cell) ____________________ (work) ____________________

Insurance Company ____________________________Carolina Access PCP # ____________________

Attach copy of card (front & back)

Diagnosis ____

☐ Lumbar Epidural Steroid Injection, _____ repeat if indicated up to 3 injections.

Specific level(s) (if any): ________________________________

☐ Selective Nerve Root Injection (Transforaminal Epidural Steroid Injection)

Level(s):____, Side: Right / Left / Bilateral

☐ Thoracic Epidural Steroid Injection, _____ repeat if indicated up to 3 injections.

☐ Cervical Epidural Steroid Injection, _____ repeat if indicated up to 3 injections.

☐ Stellate Ganglion Block, _____ repeat if indicated up to 5 injections.

☐ Lumbar Sympathetic Block, _____ repeat if indicated up to 5 injections.

☐ Facet Joint Injection (check section below)

- ☐ Evaluate and inject appropriate levels - or -
- ☐ Level(s): ____, Side: Right / Left / Bilateral

☐ Epidural Blood Patch, Level Of Myelogram/LP: ________________________

☐ Other: ____

☐ *Diagnostic Injection*

MNSC Office Use Only

Account # ____________ Appointment ____________________ Scheduled by _______ Referral taken by _____

** Please fax any pertinent imaging reports along with orders for injections **

MD RESPONSE