Alaska Center for Pain Relief

PATIENT REFERRAL FORM

Patient's Name: _____ Date: _____

Patient's Phone # or email: _____

Referring Provider (Please Print) _____

❑ **Anchorage Location** ❑ **Wasilla Location**

❑ **Dr. Christopher Gay** ❑ **Dr. Benjamin Ekstrom** ❑ **Deborah Kiley, FNP**

Evaluate and Treat:

- ❑ Neck Pain
- ❑ Lower Back Pain
- ❑ CRPS (RSD)
- ❑ Sciatica
- ❑ Headaches
- ❑ Herniated Disc(s)
- ❑ Arthritis
- ❑ Chronic Pain Medication Evaluation
- ❑ Other/Details:

Consider:

- ❑ Epidural Steroid Injections/SNRB:_____
- ❑ Spinal Cord Stimulation:_____
- ❑ Facet Joint Injections/MBB:_____
- ❑ Radiofrequency Ablation (RFA):_____
- ❑ Sacroiliac Joint Injection:_____
- ❑ Kyphoplasty/Vertebroplasty:_____
- ❑ Stellate Ganglion Block:_____
- ❑ Lumbar Sympathetic Block:_____
- ❑ Discogram:_____
- ❑ PRP/Stem Cell:_____
- ❑ Other:_____

Additional Comments:_____

_____

Referring Provider's Signature:_____

Referring Provider's Phone Number:_____

Return to Referring Provider in _____ week(s).

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