University of Wisconsin Hospital and Clinics
American Family Children's Hospital
600 Highland Avenue · Madison, WI 53792

PAIN PROCEDURE REQUEST FORM

Date of Request: _____

PATIENT INFORMATION:

Patient Name: _____ Sex: ☐ Male ☐ Female DOB: _____

Patient Address: _____ City: _____ State: ____ Zip Code: _____

Home Phone # _____Work/Cell Phone: _____

Name of Insurance:_____ Worker's Compensation: _____

REFERRING PROVIDER INFORMATION:

Clinic Name: _____

Physician Name: _____

City: _____

CONTACT PERSON WITHIN YOUR CLINIC:

Clinic Name: _____

Phone Number:_____

Fax: _____

Associated Diagnoses: _____

What procedure are you requesting: _____

Drug Allergies: _____

_____

Does your patient need an interpreter? ☐ No ☐ Yes: _____ (Language Needed)

Does your patient have a recent MRI or CT scan of the area to be injected? ☐ No ☐ Yes

If yes, list location:_____

Referring Provider Signature: _____ Date: _____ Time: _____ Pager# _____

Please fax this completed form to (608) 265-0931
If referring from outside UW Health, please also include pertinent/recent medical records.