

Appt Date/Time: _____

SPINE/PAIN PROCEDURES

Patient Name: (Last) _____ (First) _____ (MI) _____

Phone: (HM) _____ (WK) _____ DOB _____

Referring Physician: (Please Print) _____

Referring Physician Signature: _____

Referring Physician: (Phone) _____ (Fax) _____

Insurance Company: _____ Authorization Number*: _____

Reason for Consultation/ICD-9 Code: _____

- | | | |
|---|---|---|
| <input type="checkbox"/> Epidural Steroid Injection | <input type="checkbox"/> Facet Injection | <input type="checkbox"/> Sacroiliac Joint Injection |
| <input type="checkbox"/> One Injection | <input type="checkbox"/> Lumbar Injection | <input type="checkbox"/> Inject Intermediate Joint _____ |
| <input type="checkbox"/> Two Injections | <input type="checkbox"/> Cervical Injection | <input type="checkbox"/> Inject Major Joint (Pain Relief) - Hip |
| <input type="checkbox"/> Three Injections | | |

PATIENT HISTORY

Reason for visit: _____

Past Medical History (please list any medical conditions you have): _____

Past Surgical History:

| Name of Surgery | Year |
|-----------------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Please List All Allergies:

| Allergy | Reaction |
|---------|----------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Please List Your Medications (or provide a list):

| Medication | Dose | #of times/day |
|------------|-------|---------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

- Do you take:
- | | | |
|----------|------------------------------|-----------------------------|
| Aspirin | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Coumadin | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Plavix | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Lovenox | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Aggrenox | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

- Do you have (mark all that apply):
- | | | | |
|--|---------------------------------------|---|---|
| <input type="checkbox"/> Fever/Chills | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Numbness in your groin | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Constipation | <input type="checkbox"/> Numbness in your legs | <input type="checkbox"/> Joint Pain |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Leg Pain | <input type="checkbox"/> Claustrophobia | <input type="checkbox"/> Recent Falls |
| <input type="checkbox"/> Urine Incontinence | | <input type="checkbox"/> Stool Incontinence | <input type="checkbox"/> Urinary Infections |
| <input type="checkbox"/> Shortness of Breath | | <input type="checkbox"/> Home Oxygen | <input type="checkbox"/> Diabetes |

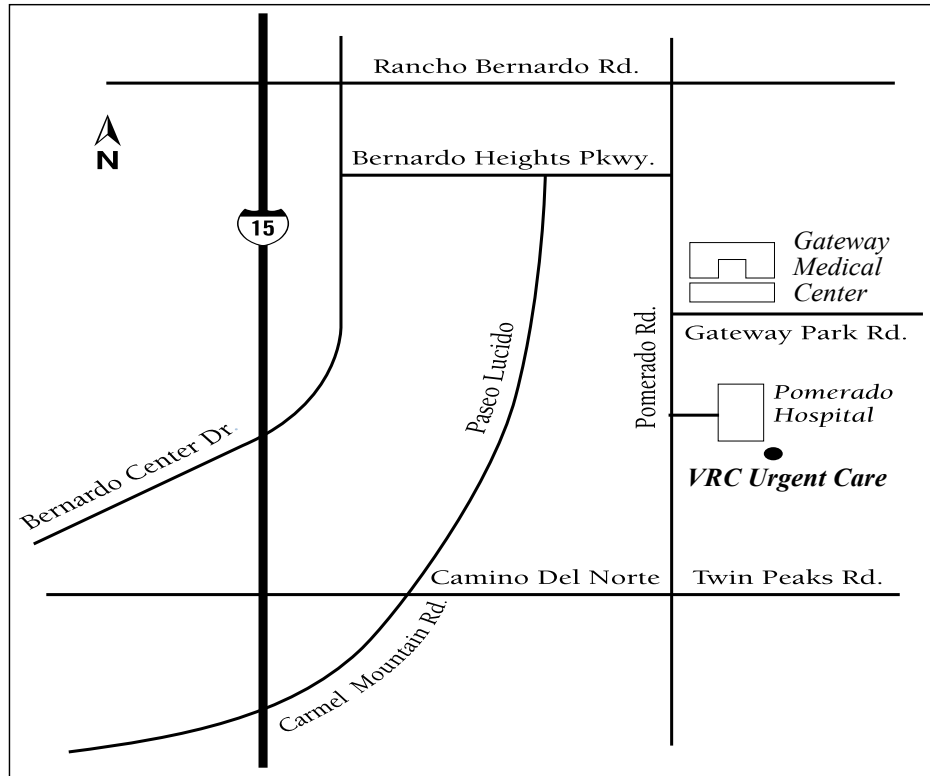
Do you have or have you ever had?
Bleeding Disorders Yes No Explain if yes: _____

Deep Vein Thrombosis Yes No If yes, when: _____

History of Cancer Yes No If yes, what type: _____

From the 15 Freeway: I-15 to the Rancho Bernardo Road Exit. Go East on Rancho Bernardo Road. Turn Right on Pomerado Road. Turn Left into Pomerado Hospital Campus.

From Ramona: Highway 67 South to Poway Grade. Go North (right) on Espola Rd. Go West (left) on Twin Peaks Rd. Go North (right) on Pomerado Rd. Turn Right into Pomerado Hospital Campus.



PATIENT PREPARATION INSTRUCTIONS:

Please bring a driver.

Please check in 15 minutes prior to your appointment.

Please wear loose clothing like pants with an elastic waist and loose shirt.

You will need to wait 15-20 minutes after the procedure before being released by physician to leave.

OTHER VALLEY RADIOLOGY LOCATIONS:

Pomerado Imaging
15725 Pomerado Road, Suite 109
Poway, CA 92064
Tel. (858) 485-6094 Fax (858) 485-6059
Services: CT and MRI (Open and High Field)

Gateway Radiology
15725 Pomerado Road, Suite 101
Poway, CA 92064
Tel. (858) 485-6500 Fax (858) 485-6542
Services: X-Ray, Ultrasound, Digital Mammography, Bone Density and Fluoroscopy

Parkway Radiology
488 E. Valley Parkway, Suite 100
Escondido, CA 92025
Tel. (760) 739-5400 Fax (760) 739-8440
Services: X-Ray, Ultrasound, Digital Mammography, Stereotactic Breast Biopsy, and Fluoroscopy