100 E. College Drive, Colby, KS 67701 ~ Phone (785) 460-4878 ~ Fax (785) 460-9320

Outpatient Pain Management Order Form

Patient Name: ____ DOB: _________________

Please check procedure and circle number of blocks to be performed SPT Code

Lumber Epidural Steroid Injection under Fluoroscopy	62323	X1	X3
Thoracic Epidural Steroid Injection under Fluoroscopy	62321	X1	X3
Cervical Epidural Steroid Injection under Fluoroscopy	62321	X1	X3
Lumber Transforaminal Steroid Injection under Fluoroscopy	64483	X1	X3
Selective Nerve Root Block under Fluoroscopy Cervical/Thoracic	64479	X1	X3
Selective Nerve Root Block under Fluoroscopy Lumber	64483	X1	X3
Diagnostic Facet or Medial Branch Block under Fluoroscopy Lumber	64493 & 64494	X1	X3
Diagnostic Facet Medial Branch Block under Fluoroscopy Cervical	64490 & 64491	X1	X3
Stellate Ganglion Block under Fluoroscopy	64510	X1	X3
Intercostal Nerve Block under Ultrasound	64420	X1	X3
Piriformis Injection under Fluoroscopy	20552	X1	X3
Joint/Bursa Injection under Fluoroscopy	20610	X1	X3
Peripheral Nerve Block under Ultrasound Guidance	64450	X1	X3
Ilioinguinal Nerve Block under Ultrasound Guidance	64425	X1	X3
Occipital Nerve Block	64405	X1	X3
Trigger Point Injection	20552	X1	X3
Tendon/Ligament Injection	20550	X1	X3
Sacroiliac Joint Injection under Fluoroscopy	27096	X1	X3
Radiofrequency Ablation Cervical	64633 & 64634	X	
Radiofrequency Ablation Lumbar/Sacral	64635 & 64636	X	
Diagnostic Genicular Nerve Block	64454		
Genicular Nerve Radiofrequency Ablation	64624		
Evaluate and Treat as Determined		X	
Other:		X	

Physician Comments and/or Request:

PRIOR TO INJECTIONS BEING SCHEDULED, ORDERING PHYSICIAN MUST PROVIDE:

- Patient demographic sheet including phone number, insurance info
- PT, PTT, CBC lab results less than 30 days, if no lab, send order for them
- MRI report of effected area done within last 1 year
- All office notes/physical therapy records pertinent to treatment requested

Unless previously approved by Anesthesia, please have all pain management patients discontinue the following medication prior to procedure:

- COUMADIN, PLAVIX, ELIQUIS, PRAXADA, XAREL TO 7 Days Prior to procedure/any epidural
- HEPARIN or LOVENOX 24 Hours Prior to procedure

Please fax completed and signed order along with requested documents to: **785-490-9320**

Physician Signature ____ Date __________________