

**Washington Interventional Spine Associates, P.S.**  
**Ray Baker, M.D. | Paul Dreyfuss, M.D. | Doug Burns, M.D.**  
**12301 NE 10<sup>th</sup> PL, Suite 101**  
**Bellevue, WA 98005**  
**(425) 454-1111 Fax (425) 454-7653**  
**www.wisaspine.com**

**PATIENT REFERRAL FORM**

Patient Name: \_\_\_\_\_ DOS: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Diagnosis: \_\_\_\_\_

- Ray M. Baker, MD                       Paul H. Dreyfuss, MD                       Doug M. Burns, MD  
 Overlake Surgery Center                       Evergreen Surgery Center

**(Check all that apply)**

- |  |
|--|
| <input type="checkbox"/> Per consultation findings, physician may modify procedure independently<br><input type="checkbox"/> Per consultation findings, physician may modify procedure only after contacting referring physician |
| <input type="checkbox"/> Perform procedure only as requested   |
| <input type="checkbox"/> Follow-up injection(s) at the discretion of the physician   |

<b>Circle appropriate procedure(s) below and indicate level and side:</b>				
<b>Procedure</b>	<b>Cervical</b>	<b>Thoracic</b>	<b>Lumbar</b>	<b>Level/Joint/Nerve and Side(s)</b>
Interlaminar Epidural Steroid Injection	62310	62310	62311	
Caudal Epidural Steroid Injection		62311		
Transforaminal Epidural Steroid Injection	64479	64479	64483	
→ Additional nerve(s)	64480	64480	64484	
Selective Spinal Nerve Block	64479	64479	64483	
→ Additional nerve(s)	64480	64480	64484	
Facet Joint Injection	64470	64470	64475	
→ Additional joint(s)	64472	64472	64476	
Medial Branch Injection (Specific joint)	64470	64470	64475	
→ Additional joint(s)	64472	64472	64476	
Sacroiliac Joint Injection		27096		
Provocation Discography	62291	62291	62290	
Radiofrequency Neurotomy	64626	64626	64622	
Sympathetic Block	64510		64520	
Costovertebral Joint Injection		64470		
→ Additional joint(s)		64472		
Hip Joint Injection		27095		

Special Request:
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**Provider:** \_\_\_\_\_                      **Provider Phone:** \_\_\_\_\_  
**Date:** \_\_\_\_\_

Washington Interventional Spine Associates, P.S.  
12301 NE 10<sup>th</sup> Place, Suite 101, Bellevue, WA 98005  
Phone: 425-454-1111 Fax: 425-454-7653

Personal

Patient Name:	Date:
Address:	
Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Social Security Number:	
Marital Status:	
Employer:	
Emergency Contact:	

Insurance

Insurance Company:	
Insurance Company Phone Number:	
Member ID:	Group #:
Policy Holder's Name:	
Policy Holder's Social Security Number:	
Policy Holder's DOB:	Policy Holder's Employer:

**Assignment and release:**

I authorize my insurance company to pay Washington Interventional Spine Associates, P.S. directly for my treatment. I also authorize the release of any medical information necessary to process these claims. I understand that, regardless of insurance coverage, I am responsible for the balance of my account. All accounts are due and payable within 60 days of the monthly billing date. The greater of 1-1/2% per month late fee or \$10.00 re-billing fee will be added to the account if past due.

I also understand that prior authorization of procedures by my insurance is not a guarantee of payment and is subject to review by my insurance company based on my individual plan.

**The above information is complete and accurate to the best of my knowledge.**

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Signature

Date

## Pre-Procedural Instructions

### General Instructions:

- Have a **driver whom you know personally** bring you and pick you up at the surgery center you're scheduled at. If you are taking a cab, you still need to bring someone to accompany you after the procedure. The cab driver is not considered a companion. You cannot drive the day of your procedure.
- Have **nothing to eat or drink for four hours** before the procedure except sips of water needed to take routine required medications.
- Allow 2-3 hours for check-in, evaluation, procedure and recovery.
- You will need to follow-up with your referring physician regarding continued management of your condition.
- If you are on **antibiotics** please notify our office, we may wait to do the procedure. **If you have an active infection or fever, we will need to reschedule the procedure.**
- Please bring a list of your **current medications**.
- If you are taking a **Medrol Dose Pak** or **oral steroids (prednisone)** please contact our office as we may ask you to stop these medications if you are receiving a cortisone injection
- Please **bring all MRI's, CT scans, CT/myelograms, and bone (SPECT) scans** of the area that we are treating. This is your responsibility. Do not trust someone else to send the films to us. Bring the actual films/CDs and not just a report. The physician will use these films to decide how to perform your particular injection.
- If you are an **insulin dependent diabetic** contact your diabetic doctor regarding possible **medication changes** the day of and several days after your procedure.
- If you are having a cervical (neck) procedure, do not wear any jewelry on the ears or neck. Men should be clean shaven from the chin to the neck.
- **Let us know** if you have a known **allergy or severe side-effects** to x-ray dye (**contrast agents**), latex, **cortisone** or **anesthetics**.
- If you are having a **diagnostic** medial branch block (MBB) or nerve root block (NRB) you **need to have enough pain** the day of the procedure **to be able to easily tell if the injection removes your typical pain**. If you are not having enough pain that day, the procedure may need to be rescheduled.
- If there is any chance you are **pregnant** then we **cannot perform** an x-ray guided **injection**.
- Let us know if you are a nursing mother. If you receive IV sedation you will need to modify your nursing schedule that day.
- In most cases plan to be off work the day of your injection.
- If you have any questions or need to reschedule, please call **(425) 454-1111**.

## Medication Instructions

Take your routine required medications (including heart, lung, high blood pressure, and diabetic pills) before the procedure with sips of water only. If you use an asthma inhaler, bring it with you.

### Medications to be held before pain management procedures:

Do not take your regular pain medicine for 6 hours before the procedure so that the physician can better assess your condition. If you are receiving a diagnostic procedure it will be best to not take pain medication in the first 6 hours after the procedure so that optimal diagnostic information is obtained.

Many medications can thin the blood and/or affect the clotting mechanism increasing the risk of bleeding. Excessive bleeding following a procedure can, at times, have serious effects including permanent nerve injury. Your physician may not perform a scheduled procedure if the medications below are not held before the procedure. **Please call the office if you are on one of these medications listed below.** You may resume these medications the night of the procedure.

### Drugs

### Hold before Procedure

Sub-cutaneous drugs: **Heprin, Lovenox** (Enoxaparin), **Innohep** .....at least **12 hours**  
(Tinzapaarin), **Fragmin** (Dalteparin), **Normiflo** (Ardeparin)

**Coumadin** (Warfarin), **Orgaran** (Damaroid)..... **6 days**  
We will need to arrange a blood draw (INR) the day of the procedure if you are on coumadin

**Plavix** (Clopidogrel) ..... **10 days**

**Ticlid** (Ticlopidine) ..... **14 days**

**Aspirin** (Cervical Procedures Only)..... **7 days**

**Garlic, Ginseng, Vitamin E (more than 400 IU/day), Feverfew, Ginger, Saw Palmetta, Dong Quai, Bromelain, Omega -3, Chondroitin** (Cervical Procedures Only)..... **7 days**

**Ginko biloba** (Cervical Procedures Only)..... **2 days**

## Pain Questionnaire

Referring Physician: \_\_\_\_\_ Primary Care Provider: \_\_\_\_\_

1. My current pain problem began (include date): \_\_\_\_\_
2. My current pain problem developed:
 

<input type="checkbox"/> Gradually over time	<input type="checkbox"/> Suddenly
<input type="checkbox"/> On the job injury: _____	<input type="checkbox"/> Motor vehicle accident: _____
<input type="checkbox"/> Other: _____	
3. I have had similar pain problems that began: \_\_\_\_\_
4. My pain is:
 

<input type="checkbox"/> 100% Neck or Back Pain	<input type="checkbox"/> 100% Arm/Shoulder or Leg/ Buttock Pain
<input type="checkbox"/> 50% Neck or Back Pain, 50% Arm/Shoulder or Leg/ Buttock Pain	
<input type="checkbox"/> 75% Neck or Back Pain, 25% Arm/Shoulder or Leg/ Buttock Pain	
<input type="checkbox"/> 25% Neck or Back Pain, 75% Arm/Shoulder or Leg/ Buttock Pain	
5. My pain is best described as (check all that apply):
 

<input type="checkbox"/> Dull	<input type="checkbox"/> Aching	<input type="checkbox"/> Throbbing	<input type="checkbox"/> Burning	<input type="checkbox"/> Toothache
<input type="checkbox"/> Sharp	<input type="checkbox"/> Stabbing	<input type="checkbox"/> Shooting	<input type="checkbox"/> Electrical	
6. My pain is worse with (check all that apply):
 

<input type="checkbox"/> Bending forward	<input type="checkbox"/> Bending backward
<input type="checkbox"/> Sitting	<input type="checkbox"/> Standing
<input type="checkbox"/> Walking	<input type="checkbox"/> Laying down
<input type="checkbox"/> Looking up	<input type="checkbox"/> Looking down
<input type="checkbox"/> Turning left	<input type="checkbox"/> Turning right
<input type="checkbox"/> Coughing / sneezing	<input type="checkbox"/> Reaching / lifting
<input type="checkbox"/> Pushing / pulling	
7. My pain is better with:
 

<input type="checkbox"/> Laying down	<input type="checkbox"/> Sitting	<input type="checkbox"/> Standing	<input type="checkbox"/> Therapy
<input type="checkbox"/> Changing positions	<input type="checkbox"/> Pain meds	<input type="checkbox"/> Ice	<input type="checkbox"/> Heat
<input type="checkbox"/> Nothing			
8. I have numbness (tingling, thickness, pins and needles, etc.):
 

<input type="checkbox"/> All the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Never	If yes, where? _____
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9. I have weakness:
 

<input type="checkbox"/> All the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Never
If yes, when and where? _____		
10. I have had the following tests for my current problem (Check all that apply)
 

<input type="checkbox"/> X-rays	<input type="checkbox"/> Cat scan (CT)	<input type="checkbox"/> CT/Myelogram
<input type="checkbox"/> MRI	<input type="checkbox"/> EMG	<input type="checkbox"/> Bone/SPECT scan
<input type="checkbox"/> Diagnostic Spinal Injections (e.g. nerve block, facet/sacroiliac joint block, discogram)		
11. I have tried the following treatments for my pain (Check all that apply and circle those that helped):
 

<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Manipulation (e.g. manual therapy, chiropractic)	<input type="checkbox"/> Acupuncture/ Massage
<input type="checkbox"/> Spinal Injections	<input type="checkbox"/> Home/gym exercises	<input type="checkbox"/> Spinal Surgery
<input type="checkbox"/> Traction		
12. I have tried the following medications for my pain (Check all that apply and circle those that helped):
 

<input type="checkbox"/> Anti-inflammatories (eg. Motrin, Naproxen)	<input type="checkbox"/> Muscle relaxers (e.g. Soma, Flexeril)
<input type="checkbox"/> Anti seizure drugs (e.g. neurontin, topamax)	<input type="checkbox"/> Narcotics
<input type="checkbox"/> Anti-depressants (e.g. Paxil, Zoloft)	