Innovative Care Management

Please complete and FAX this questionnaire <u>with</u> the following clinical information to 503-654-8570:

1. ***History & Physical*** prior to initial injection.
2. Most recent ***office visit note(s)*** documenting care and noting specifics of above pertinent findings.
3. Most recent ***imaging reports***, i.e., X-ray, MRI, CT

Patient Name: _____ DOB: _____

Submitted By: _____ Phone: _____ Fax: _____

Physician: _____ Phone: _____ Fax: _____

Facility: _____ Phone: _____

Please indicate the ***type of injection*** requested:

❑ Epidural Steroid Injection
❑ Facet Injection
❑ SI Joint Injection
❑ Trigger Point Injection
❑ Medial Branch Block
❑ Radiofrequency ablation (RFA)

STOP IF THIS IS NOT AN INJECTION SPECIFIED ABOVE!

Other form available at: http://www.innovativecare.com/preauth/

CPT code(s): _____ ICD9 code(s): _____

Please indicate the ***level(s)*** of this injection (e.g. L5-S1): _____

Is this a bilateral injection: ❑ YES ❑ NO If unilateral, please ***check***: ❑ Right or ❑ Left

Please indicate the ***date of service*** for this pending request: _____ or ❑ Not Scheduled

Does the patient have any of the ***following conditions***?	❑ Coagulopathy ❑ Injection site infection ❑ Increased Intracranial pressure ❑ Epidural metastases ❑ Septicemia ❑ None of the above conditions
Has the patient been treated with **anti-inflammatory drugs**? (NSAIDS, etc.)	❑ Yes ❑ No How long? _____
Has the patient been treated with **conservative therapies**?	❑ Yes ***(indicate length of time in space)*** _____Physical therapy _____Chiropractic _____Activity modification ❑ No
Has the patient had a prior spinal injection at this level?	❑ Yes ❑ No

Please provide the Dates, Levels, Response, and Duration for injections in the last 12 months:

NOTE: If this is the first injection, please check here ❑

Date	Injection Type (i.e., facet, ESI, etc.)	Level(s)	Response (% relief)	Duration (Week, Month, etc)