Fast Track Procedures
Referral Request Form

TOUCHSTONE
INTERVENTIONAL PAIN CENTER

Shawn Sills, MD
Anesthesiologist Specializing in Pain Management

Patient Information

Patient Name: _____

DOB: _____ Sex: M or F SS#: _____

Phone: _____ Work/Cell: _____

Address: _____

City: _____ State: _____ Zip: _____

Referring Provider Information

Referring Provider: _____ PCP: _____

Office Contact: _____ Phone: _____ Ext: _____

Reason for Referral

- ◯ Epidural Steroid Injection
- ◯ Facet Joint Injection
- ◯ Medial Branch Block/ Radiofrequency/Neurotomy
- ◯ Sympathetic Chain Block
- ◯ Sacroiliac Joint Injection
- ◯ Peripheral Nerve Block
- ◯ Spinal Cord Stimulator Trail
- ◯ Intrathecal Pain Pump
- ◯ Knee/Hip/Shoulder Joint Injection
- ◯ Other _____
- ◯ Levels_____

Insurance

Primary Insurance:_____ Policy/ID Number: _____

Group Number: _____ Group Name: _____

Secondary Insurance: _____ Policy/ID Number: _____

Group Number: _____ Group Name: _____

❍Worker's Compensation ❍Motor Vehicle Accident

Insurance: _____ Claim Number: _____

Date of Injury: _____ Authorization Number: _____

Adjuster Name: _____ Phone: _____ Ext: _____