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Oklahoma Surgical Hospital
 at Citiplex Towers
 2408 E 81st Street, Ste #300
 Tulsa, OK

SouthCrest Hospital
 at I-169 & 91st St
 8801 South 101st East Avenue
 Tulsa, OK

PATIENT INFORMATION	
Patient Name	Patient Phone #
DOB M/F	SSN
Procedure Date/Time	Status: <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient
Physician to Perform: Dr. Webb	ICD-9 Code:
Referring Physician Name	Referring Physician Phone #
Diagnosis: <input type="checkbox"/> Vertebral compression fracture (VCF) <input type="checkbox"/> Back pain <input type="checkbox"/> LBP <input type="checkbox"/> Disc Disease <input type="checkbox"/> Radiculopathy <input type="checkbox"/> Neck Pain <input type="checkbox"/> Other (specify)	

PROCEDURE INFORMATION				
Epidural Steroid Injections & Spine	Vertebral Compression Fractures (VCF)	Joint Procedures	Discogram	Ganglion/Plexus Blocks
<input type="checkbox"/> LESI <input type="checkbox"/> TESI <input type="checkbox"/> CESI <input type="checkbox"/> Facet injection <input type="checkbox"/> SI Injection <input type="checkbox"/> RF ablation <input type="checkbox"/> Selective NRB (specify: _____) <input type="checkbox"/> Disc Aspiration <input type="checkbox"/> Biopsy <input type="checkbox"/> Other: (specify)	<input type="checkbox"/> Evaluate/& treat VCF Level (if known) Comorbidities (check all that apply): <input type="checkbox"/> DM <input type="checkbox"/> CAD <input type="checkbox"/> HTN <input type="checkbox"/> COPD <input type="checkbox"/> Depression <input type="checkbox"/> Cancer (Specify): <input type="checkbox"/> Other: (specify)	<input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Bilateral <i>Specify joint:</i> <input type="checkbox"/> Shoulder <input type="checkbox"/> Hip <input type="checkbox"/> Knee <input type="checkbox"/> Other _____ <input type="checkbox"/> Injection <input type="checkbox"/> Aspiration <input type="checkbox"/> Arthrogram <input type="checkbox"/> Biopsy <input type="checkbox"/> Other: (specify)	<input type="checkbox"/> Routine (L3-S1) <input type="checkbox"/> Routine (L2-S1) <input type="checkbox"/> L1/2 <input type="checkbox"/> L2/3 <input type="checkbox"/> L3/4 <input type="checkbox"/> L4/5 <input type="checkbox"/> L5/S1 <input type="checkbox"/> Other: (specify)	<input type="checkbox"/> Trigeminal <input type="checkbox"/> Celiac <input type="checkbox"/> Hypogastric <input type="checkbox"/> Sympathetic <input type="checkbox"/> Peripheral block <input type="checkbox"/> Other: (specify)

INSURANCE INFORMATION	
Insurance Company	Policy #
Customer Service #	Other

INTERNAL USE ONLY	
Taken By	Date
Scheduled By	Date

To expedite scheduling, please have physician's order to "evaluate and treat", as well as any available H&P, labs with coags, allergies and current medications with this sheet.

Thank you for your referral.
Please fax all orders to (918) 806-6672